STRENTGTH IN WEAKNESS:

A BIBLE BASED MODEL

FOR HEALING A FAMILY

AFFECTED BY ADDICTION

A THESIS SUBMITTED TO THE FACULTY

OF GORDON-CONWELL THEOLOGICAL SEMINARY

IN PARTIAL FULFILLMENT OF REQUIREMENTS

FOR THE DEGREE

DOCTOR OF MINISTRY

BY

WILLIAM A. WILSON

JUNE, 2006

TABLE OF CONTENTS

Acknowledgements

I thank God who has struggled with me and encouraged me throughout my life. I have learned that without the power of the Holy Spirit in me I can do nothing.

I thank my wife Kim who has sacrificed in many ways over the past few years so that I could complete this part of the journey God called me to. I am blessed by her presence in my life.

My daughters Heather and Michele, and her husband Jim, have been encouraging and a blessing to me.

I thank Todd and Cooper my stepsons who have been supportive of my study time. We can play more now.

I am grateful to Mike Murphy who provided supervision and encouragement during my practicum experiences.

Drs. Sid Bradley and Ray Pendleton have been inspiring and enlightening as my professors and mentors.

Patricia Nielson, Dr. Bradley's Administrative Assistant, has been a solid source of support.

Barbara Schmitz, my office manager, has made it possible for me to be away and focus on this journey.

All Scripture quotations are from the Holy Bible New Living Translation unless otherwise noted.

Abstract

The purpose of this study is to call attention to the church the significant detrimental impact that substance and behavioral addictions are having on families today and to present a Bible based model for counseling and restoring those families.

The first chapter will present an overview of the impact of addictions on families. Cognitive behavioral theory and therapy for addictions will be described.

The second chapter will present this writer's understanding of God's design for the family and the cause of the fall of humanity from grace.

The third chapter will present a review of the literature which the author found most helpful in dealing with the problems caused by addictions. Theological support for cognitive behavioral therapy will be presented.

The fourth chapter will present the history, individual diagnoses, and a genogram of a family affected by addictions.

The fifth chapter describes lessons learned by the writer and suggestions for those who counsel people with addictions. A brief addendum describing the progress of the therapy follows the fifth chapter.

Chapter One

An Understanding of Addictions and the Family in a Systemic Framework

Introduction

Abuse of and addiction to alcohol and other substances and behaviors such as sex and gambling are destroying many families. As a marriage and family therapist for over 30 years, this author has observed the significant detrimental impact that addictions have on families and the lack of awareness that most therapists, pastors, and health care professionals have in the assessment and treatment of addictions, especially in a family context. The Christian church has tended to ignore or minimize the problem. Training programs in marriage and family counseling in secular as well as Christian colleges, universities, and seminaries have not prepared therapists adequately to help with this problem. Prisons are overflowing due to crimes related to alcohol and other addictions. Church pews have plenty of room.

Alcohol abuse and dependence are among the most prevalent mental disorders in the United States today. A 1992 survey sponsored by the National Institute on Alcohol Abuse and Alcoholism estimated that approximately fourteen

million Americans had an alcohol use disorder. The study indicated that approximately twenty one percent of Americans experienced at least one alcohol related problem in the prior year and that roughly one in three Americans engaged in risky drinking patterns (Roberts & McCrady, 2003, p.4).

The rate of addiction related problems is high in the general population and it is considerably higher in people who seek help for other identified problems. There is a high rate of co-morbidity between alcohol and other addictive disorders and psychiatric disorders. A strong association exists between substance abuse disorders, pathological gambling, sexual addiction and mood regulation, stress, and interpersonal and family problems (Beck, Wright, Newman, & Liese, 1993, p. 10). Many people who seek counseling for marriage and family issues may also be experiencing an addiction related disorder. Untrained counselors often try to treat the presenting problem without assessing for an addiction in all members of the marriage or family system. It is the opinion of this writer that unless the addiction, if there is one, is treated, no progress can be made in healing other issues. The addicted person or persons will tend to turn to the drug of choice

before turning to the skills learned to manage depression, anxiety, or marital conflict.

The negative effects of alcohol and other addictions not only affect the user, but also can be seen in other family members. Negative effects include marital and family violence, unresolved conflict, economic problems, infidelity, and fetal alcohol syndrome. Substance abuse problems have a definite negative impact on family problems, and it has been observed that family problems can contribute to the increased use of the substance. Addiction problems are common in couples who seek marital therapy and marital problems are common for those seeking help for an addiction.

This writer believes that if we are to be of true help in the healing and restoration of marriages and families, we must as Christian counselors and pastors be aware of the significance of the impact of addictions and be prepared to assess and provide treatment and resources to address the whole problem. As an example of a holistic approach, Rick Warren of the Saddleback Church in Southern California has on several occasions attributed a significant amount of that church's growth to the Celebrate Recovery ministry for

the healing of addictions which they developed and promote heavily each Sunday.

The purpose of this thesis is to emphasize the significance of the problem and to propose a method for treating individuals and families affected by an addiction in a Christian context.

An Approach to the Treatment of Families Affected by Addiction

This writer has been a marriage and family therapist in a secular setting for over thirty years. His early training was in family systems theory and in cognitive behavioral therapy. Particularly the cognitive theory and therapy developed by Aaron Beck and his associates (Beck, Rush, & Emery, 1979).

Cognitive behavioral therapy for addictions has been chosen as the preferred treatment by the writer for several reasons.

1. It is well studied and documented to be an effective treatment for other psychiatric disorders such as depression and anxiety.

2. It is a collaborative treatment involving the client, family, and the therapist.

3. It is goal oriented and structured.

4. It sees other therapies such as medication, twelve-step support groups, Celebrate Recovery, and prayer as complementary.

5. It has a clear model of understanding substance abuse and relapse prevention.

6. It is consistent with Scripture.

Cognitive Behavioral Model of Addiction

People have been turning to substances and behaviors to obtain pleasure, experience the exhilaration of being high, and share the experience with companions since the beginning. In Genesis 3:5 we are told that Eve ate of the fruit of the tree of the knowledge of good and evil because it would make her like God, knowing everything both good and evil. Adam, who was with her, ate of it also. They evidently wanted to feel even more powerful, as they had become habituated to the good life God had already given them.

Later the Israelites became nervous and impatient when Moses did not come down from the mountain fast enough. They asked Aaron to make them some gods out of wood and gold to lead them to safety, to reduce their anxiety (Exodus 32). People have been turning from the truth to false idols,

substances, and behaviors to make them feel better since the fall of humanity from grace.

No matter whether the drugs or behaviors are legal, such as alcohol and nicotine, some forms of pornography, promiscuity, and gambling or illegal such as cocaine, methamphetamine, and marijuana, the drug seems to take control of the addicted person. As individuals become habituated to it, they need more and more to maintain their high. Their goals, values, families, and health become subordinate to the addiction. The vicious cycle of craving, drops in mood, and greater distress which can only be relieved by using the drug begins. People with addictions often promise themselves they will stop or control their use. Then they use again when a "trigger" occurs. They feel more guilt and shame which they then numb with the drug. Turning to addictive drugs and behaviors in reality is allowing the problems to increase rather than reduce them. Family, financial, legal, and health consequences follow.

Beck's original model of cognitive behavioral therapy (Beck, Rush, & Emrery, 1979) holds that as we grow up, our environment, primarily the family, influences the development of deep-seated core beliefs or schemas about ourselves, the world, and other people. These core beliefs

lead to assumptions about our selves, our abilities to deal with life, and our relationships. The assumptions lead to automatic thoughts which control the way we respond to every situation or event in our lives. Some of these core beliefs, assumptions, and automatic thoughts lead to positive, healthy outcomes. Some may be very dysfunctional leading to problems. Beck's original model of therapy helps the individual patient recognize the problems and develop an overall realistic concept of the problems and set goals to alleviate them. Patients learn to recognize and reprogram the dysfunctional automatic thoughts with healthy, more functional ones. They are encouraged to learn to think about options and choose healthier ones. The therapy goes deeper by then helping the patients to look at their own developmental issues, the environment, and the family system which contributed to the negative core beliefs.

A key to the successful treatment outcome is the therapeutic alliance. The counselor must demonstrate warmth, empathy, caring, genuine regard, and competence. Cognitive therapy emphasizes collaboration and active participation by the client or clients and the therapist.

Cognitive therapy is goal oriented and problem focused. Initially it stays focused on the present, especially crisis situations. The therapist helps the patient and other family members to identify the specific problems which led to their seeking therapy. They are encouraged to set specific goals and to identify and evaluate the thoughts which interfere with being able to achieve those goals. They then test the new thoughts in similar situations and evaluate the results. As the patient builds more skills and the situation is somewhat improved, work begins on assumptions and core beliefs. As they dig deeper into past events and their interpretations of their meanings about themselves, other people, and the world, they begin to recognize misunderstandings and misinterpretations and replace or adjust those assumptions and beliefs with more functional healthy ones.

Cognitive therapy encourages patients to learn in some ways to be their own therapist. Helpful tools such as thought records and anxiety rating scales are used.

Cognitive Theory of Addictions

Beck, Wright, Newman, and Liese (1993) published *Cognitive Therapy of Substance Abuse* to address the need for effective treatment of a significantly growing problem.

The book which has been extensively researched is based on Beck's cognitive model which was first published in 1976.

Cognitive therapy is a system of psychotherapy that attempts to reduce or eliminate excessive emotional reactions and self defeating behaviors by modifying the faulty or erroneous thinking and maladaptive beliefs that underlie these reactions (Beck, 1976; Beck, Rush, Shaw, & Emery, 1979).

The approach to each case is derived from a thorough conceptualization of the case based on the cognitive model of that disorder. The conceptualization includes developing an understanding of the relationship of early life patterns to current problems. The cognitive approach is (1) collaborative (building trust) (2) active (3) based on open-ended questioning to a large degree, and (4) structured and focused.

This writer has found this format especially helpful in working with substance abuse issues for individuals and families. The cognitive approach helps the individuals learn to identify the problems leading to emotional distress and to understand their reliance on drugs or behaviors for pleasure and relief from discomfort. The patients learn specific strategies to reduce their urges

and at the same time establish a stronger system of internal controls. This writer finds this therapy to work especially well because he uses the same format to help patients to deal with their anger, depression, anxiety, and marital issues which often trigger the addictive behaviors.

Cognitive therapy for addictions is designed to help patients in two ways: (1) to reduce the intensity and frequency of urges by undermining the dysfunctional core belief and (2) to teach patients specific techniques for controlling or managing their urges (Beck et al., 1993). Patients learn to examine the sequence of events leading to drug use and then to explore their basic beliefs about the value of the drug or behavior. They are trained to evaluate the ways the faulty thinking produces stress and distress. Patients learn to modify their thinking so that they can better understand their real problems and disregard the pseudo-problems caused by their faulty thinking. They learn to recognize situations which may trigger the faulty thinking, leading to lapse and relapse in the future and to have a plan to deal with the strong urges which will occur from time to time. This approach is consistent with Alcoholics Anonymous and other complimentary programs.

The therapist helps patients find satisfactory ways of coping with realistic problems and unpleasant feelings without turning to their addictive drug or behavior for relief. Cognitive therapy for addictions encourages patients to learn new interpersonal skills like assertiveness and conflict management.

At the heart of cognitive therapy is a technique which this writer has found helpful in dealing with many other problems as well. By using a method called guided discovery or the downward arrow technique, the therapist asks questions which lead the patients to examine the areas of their lives that they have been in denial about or minimizing, such as the full impact of the drug use on their own lives, and that of their family (Epstein & Baucom, 2002, p. 357; Padesky & Greenberger, 1995, p. 10-11). Patients then learn to develop alternative solutions to their habituated, addictive thinking. They learn to question their own dysfunctional beliefs and look for options and evaluate them as objectively as possible (Beck et al., 1993; Greenberger & Padesky, 1995).

Addictive beliefs are common across all types of addictions. These beliefs are held by most addicts and contribute to maintaining the addiction and often lead to

lapse, the first returning to use of the drug after treatment, and relapse, continuing to use. In order to prevent the return to using the drug, the patient's beliefs and attitudes about drug use must be significantly changed. It is too common that people who go through addiction treatment programs lapse back into using addictive drugs or behaviors. One of this writer's patients returned to consuming alcohol on the airplane as she returned from one of the leading 30 day inpatient treatment programs in the country. Cognitive behavioral therapy helps patients to recognize triggers and situations such as being extremely stressed or tired which may lead to the return of their old addictive thinking and thus to full relapse.

Patients are taught to recognize "cravings" as a desire for the particular drug or behavior and "urges" as internal pressure to act on the craving. The process is similar to a compulsive behavior satisfying an obsessive thought. It is important that patients deeply understand the process and develop the skills to manage these thoughts or cravings when they occur. By the time a person has become addicted to a substance or behavior, the addictive beliefs are so deeply rooted that changing them is incredibly difficult. When the patients understand this and

fully accept the fact that they are no longer in control of their lives, they have a chance for sobriety. The Apostle Paul stated in 2 Corinthians 12:10 that he celebrated his weaknesses. Paul understood that he was strong when he learned to rely on God and those God sent to help him. Then he was able to accomplish the work God called him to do.

Beck's cognitive theory of addiction holds that many addicted individuals have not developed the skills to control temptation. The therapist's role is to help them develop those skills. Rehearsing healthy responses to temptations in the counseling office is one technique. The therapist teaches the patients to imagine themselves in situations where in the past the temptation to use the drug or the behavior was strong. Then the patients practice the behavior of responding to the temptation in a healthier way. This situation is an excellent place for the memorization of Scripture passages to be utilized. God says his Word should be written on our hearts. The cognitive behavioral therapist can assist the patient in memorizing relevant passages from Scripture as well as other healthier thoughts which will help him to respond in a more rational way when temptation does arise.

This writer is especially in agreement with the principle that “will power” is not the answer to the healing of any addiction. Cognitive theory suggests that it is the strength of commitment to sobriety that is the key to success. The strength of commitment implies the willingness not only to recognize, but to fully accept our weaknesses. Thus the cognitive therapist, through guided discovery, helps patients attach a true value to sobriety. Will power by itself may weaken under stress and the addictive thinking and behaviors will return. The Apostle Paul tells us in Ephesians 6 to put on the full armor of God so that we will always be prepared for the strategies and tricks of the devil.

Beck et al. (1993) describe a core set of addictive beliefs which serve to maintain the addictive behavior after an individual has become addicted. These are seen as a cluster of ideas which are centered around problem solving, relief, and escape. Some of the dysfunctional ideas are; (1) the belief that one needs the substance if one is to maintain psychological and emotional balance; (2)the expectation that the substance will improve social and intellectual functioning; (3) the expectation that one will find pleasure and excitement from using;(4) the belief

that the drug will energize the individual and provide increased power; (5) the anticipation that the drug will have a soothing effect; (6) the conviction that unless something is done immediately to satisfy the craving it will continue indefinitely and possibly get worse. Very common in this writer's experience is a set of justification and entitlement beliefs which patients use to return to their drug. Examples would be "I haven't had a drink in a month. I'm not really an alcoholic. I can have one drink to relieve my stress." "I really need a hit now. I'll just smoke this one joint and quit next week."

Cognitive theory of addiction states that there are certain predispositonal characteristics of people who become addicted to drugs and behaviors. They may have for example (1) a general sensitivity to their unpleasant feelings; (2) deficient motivation to change behavior (instant satisfaction is more highly valued than control); (3) inadequate techniques for controlling behavior and coping with problems; and (4) a pattern of yielding to impulses automatically. One of the most significant precursors is a low tolerance for frustration (Beck et al., 1993).

Attitudes toward usual sources of daily frustrations magnify the reaction and lead to excessive disappointment and anger. Without the coping skills taught by cognitive therapy some of these individuals turn to drugs or addictive behaviors to temporarily relieve their anger. As stated earlier, cognitive therapy teaches patients to examine their faulty beliefs and to replace them with more functional ones. Beck et al. (1993) point out that individuals may have such conflicting beliefs about using or not using drugs that the stress leads them to relieve the situation by using again.

The therapeutic application of the cognitive theory of addiction consists of modifying the individual's belief system and teaching how to avoid or cope with high risk situations.

Healing of Addictions: A Therapeutic Family Systems Approach

As stated earlier most marriage and family therapists see couples or families with addictive disorders. The addiction may be identified by the couple as a secondary issue (i.e. "he drinks a little too much sometimes"), when in fact it may be the primary issue or exacerbating the primary issue. It may be circular in that the marriage or

family problem leads the addicted person to use the drug thus exacerbating the marriage or family problem. If both partners are addicted each may be reluctant to mention the other's use for fear they will have to address their own problem. They may not even mention it at all if the therapist does not ask. Denial and minimization of substance or behavioral abuse and addiction are common symptoms of the problem. A competent marriage and family therapist must be aware that one or both members of a marriage may have a substance or behavioral abuse or dependency disorder and that if it exists, it will prevent a positive outcome for any other issues for which the couple or family may have sought help. As previously mentioned the addicted person will turn to the drug to relieve pain before practicing any skills taught in therapy. A survey conducted for the American Association for Marriage and Family Therapy revealed that 84-88 percent of marriage and family therapists see clients with alcohol problems (Roberts & McCrady, 2003, p. ii). It has been this writer's experience that family therapy with two parents and one or more children with substance abuse or behavioral addictions is not uncommon. Addiction to drugs and behaviors affect every member of the family.

According to the Substance Abuse and Mental Health Services Administration (SAMSHA), children of alcohol addicted parents can suffer from educational deficits, behavior problems and alcohol abuse in later life. Children of alcoholics are two to four times more likely to become problem drinkers and continue the addictive practices of their parents with similar devastating results. SAMSHA Administrator Charles Curie states:

> We know that children of alcoholics are at greater risk for substance abuse problems in their own lives. But we also know what to do to help them avoid repeating their families' problems. We can break the generational cycle of alcoholism in families (Breaking the cycle of addiction, 2006).

This writer has reviewed the basic theory of cognitive therapy and specifically the cognitive theory and therapy of addictions. Some of the devastating effects that addictions can have on individuals, marriages, and families have been described.

How do we address these and other problems in marriage and or family therapy?

A Cognitive-behavioral Approach to Family Therapy for Addictions

"The cognitive-behavioral approach to families is consistent and compatible with systems theory and includes the premise that members of a family simultaneously

influence and are influenced by each other" (Nichols & Schwartz, 2001, p. 97).

Dattilio and Padesky (1990) suggest a three-step approach to beginning couple or family therapy. The first step is a meeting with the couple. This writer believes that a meeting with the married couple together without children present initially is preferred because it allows for an opportunity to observe how the individuals function as a couple. The history of their marriage, information about their families of origin, how they met, qualities which attracted them to each other, any previous marriages, and other relevant information should be taken. The therapist can observe communications patterns and other behaviors which may be clues to the identified problem. The therapist may also evaluate if this couple is suitable for marriage or family therapy at this time. In the case where an affair or an addiction is disclosed, the therapist can discuss importance of stopping the affair and/or committing to sobriety before couples or family therapy could be productive.

During the conjoint interviews written questionnaires regarding the marriage may be administered. There are several of these which are fairly simple to administer and

provide helpful information to the therapist. The Locke-Wallace Marital Inventory and the Marital Satisfaction Inventory are two which have been empirically validated. The Enrich Marital Inventory is well researched and now available online. It can be taken in the therapist's office or given as homework between sessions. During the first session it is important for the therapist to explain to the couple the basics of cognitive therapy and that the first few sessions will be for the purpose of assessing the problems and developing a concept of how both spouses see this relationship, what they thought a marriage would be like before they married, and identifying some goals. If significant individual psychopathology is suspected, the therapist should arrange for further testing at that time.

Because addictive thinking and behaviors are developed and grow within a family system, it is important that as many members of the family as possible be included in the healing process. Systems theory holds that if one member of the system does not understand what the goals are and the importance of the changes that will need to be made that member may sabotage any progress. For example the spouse of a person who is dependent on alcohol will make it difficult

for him or her to remain sober if alcohol is continually brought into the house.

The second step in counseling would be a meeting with each individual. This provides an opportunity for the therapist to interact with each partner in a somewhat more relaxed atmosphere. The therapist notes the differences in interaction patterns when the partner is present and when not. This writer finds it preferable to allow the partners to choose who "goes first" so as to minimize any possibility of the therapist labeling one or the other as the "most sick." Individual assessment sessions allow for disclosures about issues which the partner may not have been comfortable discussing in the initial conjoint session. This point is also an opportunity for the therapist to ask again about potential sensitive issues like alcohol or drug abuse or addictive behaviors. Questions about the individual's personal use of addictive substances or behaviors and his or her beliefs regarding the partner's substance use would be appropriate here. The therapist may then meet with other family members to allow for input on their views of their family and any changes they would like to see made.

The third step, not the third counseling session, would be for the therapist to meet again with the couple and other family members in order to present his or her assessment of the problem and to develop an overall case conceptualization and treatment plan. The therapist presents the initial assessment of the situation and asks for feed back from family members. It is important that the family understand cognitive therapy as a collaborative therapy. Their input and participation in the diagnosis and the treatment plan is vital. All members of the family should see the relationship difficulties as a family problem which will improve only if they work together toward a common goal.

The importance of the assessment process cannot be overemphasized in the opinion of this writer. It is the time to begin to build the warm, trusting, collaborative relationship with the entire family which is vital to the positive outcome of therapy.

Once the initial assessment has been completed and an agreement on the goals is reached the therapist should then seek the couple’s commitment to treatment. An important factor to successful therapeutic outcome for addicted individuals and their families is the value that they place

on changing (Beck et al.1993, p. 37). A person who values the drug more than his or her family will make little effort to live soberly.

After a full assessment, cognitive behavioral family therapy for addiction begins by helping the couple to identify their own automatic thoughts about themselves and about the relationship. Automatic thoughts are those which occur spontaneously in each individual. They are based on the core beliefs that the individual developed as he or she grew. These beliefs and thoughts may be positive or negative. Cognitive therapists work with the family members to help them recognize their automatic thoughts and to uncover the beliefs which drive them.

Each member of the marital dyad will have automatic thoughts and beliefs not only about themselves but also about what a marriage should be like. It is important to help them to share those with each other and to develop a common set of healthy beliefs about what they would like their marriage and family to be. They are taught to use a tool such as a "Daily Record of Dysfunctional Thoughts" which helps them to recognize situations that trigger distorted thoughts. Clients can then examine the evidence of the truth of that thought, and learn to restate it in a

more rational way. By changing the thoughts, the uncomfortable feelings which the client numbs with drugs are relieved, at least to some extent. The clients are encouraged to keep materials such as three by five cards, or small notebooks handy so that they can practice the skill regularly.

This author has found that it is important to be selective about the dysfunctional thoughts the clients choose to work on at first, and when working with addictions, that only one or two different thoughts are focused on at one time. It important that the client practice using the thought record and understand that the "reprogramming" will take some time. When one or two have been successfully mastered, others may be chosen.

Dattilio and Padesky (1990) indicate that it is critical to identify the couple's beliefs about the possibility of change. This determination seems especially important to this writer when working with a family affected by addiction. Many people who come for treatment for addictions do not initiate the treatment themselves. They may have attempted many times to control it by using will power. If the family member with an addiction begins treatment, he or she will not usually be open, honest, and

trusting with the therapist at first. Cognitive theory of addiction holds that it is the underlying core beliefs which must be corrected in order for healing to be effective over the long term. If the addicted person does not even believe change is possible, the therapist will need to help that person recognize that belief deficit and use the thought records and guided discovery to develop a more rational belief first. It would be a mistake to go forward with treatment otherwise.

Cognitive behavioral therapy for couples or families follows a structured model. It should be explained in the earliest session that there are ground rules. These rules would include such items as following a collaboratively set agenda at each therapy session and discouraging attempts to contact the therapist outside the scheduled appointments in order to get him or her aligned with that partner's point of view.

During the first few sessions the clients are taught that both partners must accept responsibility for the distress in the relationship and therefore for the healing. In each session they are encouraged to share their daily record of dysfunctional thoughts and to work together to come up with a more balanced or rational way of thinking

about each situation. They should begin to see that they do not think exactly alike about their lives and will be able to develop alternative thoughts and beliefs which will work for them as a couple or family. They would be expected to test these thought patterns during the next week and record the results. Necessary adjustments are discussed and written during the therapy session and then tested again until a workable collaborative solution is found.

Because the beliefs and the thinking of people who are addicted to a drug or behavior are so distorted and dysfunctional, the therapist must have an understanding of addictions and the knowledge and extra patience required to work with them. This writer believes that any addiction is primarily a thinking disorder. Distorted thinking leads to cravings which lead to using the drug again or acting out on the behavior such as watching pornography on the internet and masturbating while fantasizing. Research on the neurochemistry of behavioral addictions indicates that the brain can become habituated to the higher levels of neurotransmitters such as serotonin, dopamine and norepenephrine which help to elevate moods (Carnes & Adams, 2002; Comings, 1998). These induced mood states are generated by the individuals thought processes. One of this

writer's clients reported going from an almost suicidal state of depression upon leaving a casino, two hours from her home, having lost over $20,000.00 to a very strong "high" by thinking about a way to get the money in order to go back to the casino where she was sure she would win big and get out of debt. In gambling treatment this is known as the "chase" (Lesieur, 1984) and is what keeps the addict coming back for more. Gambling addicts are reported to have the highest rate of suicide of any of the addictive disorders (Cox, Lesieur, Rosenthal, & Volberg, 1997, p. 14).

It is not the purpose of the author to write a complete treatment manual on the cognitive behavioral family therapy for addictions. Dattilio and Padesky (1990) have described a nine stage model for cognitive therapy with couples which will work quite well with a few adaptations for dealing with addictions.

1. History and conceptualization of the problem. This would include a complete assessment for addiction issues and explaining the treatment model.

2. Crisis reduction or anger management issues and an understanding of the importance to the commitment to

sobriety and fidelity to the marriage if progress is to be made in healing of the relationships.

3. Increasing positive behaviors in the relationship. This helps to motivate the couple to see the value of making the necessary changes.

4. Teaching the couple to identify, test, and respond to automatic thoughts. This is especially important in a family system which because of distorted automatic thoughts such as “She made me so angry. I need a drink.” by the husband and the wife’s “It’s my fault he has to drink so much. I’ll just try to be a better wife and not complain.” These distorted thoughts simply perpetuate the problem.

5. Teaching communication skills. There are several good communication skills programs available such as the Christian Prep, and Couples Communications programs. They will not be used if one or both clients are continuing in their addictive behaviors.

6. Dealing with anger issues. As therapy progresses and the relationship begins to heal, the couple can begin to identify the deeper lying doubts, hurts, and fears which may lead to anger situations.

7. Problem resolution strategies. Build on the communication skills developed to explore and reach a collaborative consensus on problems.

8. Identifying and changing dysfunctional attitudes and core assumptions. This knowledge is important for all couples, especially those with rigid belief systems which are characteristic of addicted couples. They learn to identify the roots of their dysfunctional core beliefs and to construct more adaptive attitudes through carefully designed experiments. A typical experiment for example would be for an alcoholic to predict what would happen if he or she went a day without drinking. The person would keep a record of what did happen during that day and examine the truth of that thought.

9. Relapse prevention. This stage includes reviewing problem solving strategies the couple had learned. Incorporating principles learned in a recovery program such as Celebrate Recovery or Gamblers Anonymous into the plan for addictive couples is critical. Scheduling check up visits with the therapist helps to assure compliance and accountability.

Summary

While cognitive behavioral family therapy for addictions is relatively new in the treatment of addictions and the published research is sparse, this author believes that it holds great promise. As stated previously, it focuses on helping the client to recognize deep-seated core beliefs which have led to dysfunctional thoughts and then behaviors which are not consistent with a well functioning family life. The client, which may include the spouse and other family members, learns principles and techniques for recognizing the dysfunctional beliefs, thoughts, and behaviors. They learn to accept responsibility for whatever they may have contributed to the problem, deal with their own guilt and shame, to forgive and accept forgiveness, and to make the commitment to heal together. For example a husband may attend Al-Anon meetings while his wife is attending Alcoholics Anonymous and the children attend Ala-teen.

In this chapter the writer has covered the basics of Aaron Beck's cognitive behavioral theory and psychotherapy and how it has been adapted to couples and family therapy in recent years. It is based on the development of dysfunctional core beliefs primarily from our family of

origin which lead to distorted thinking patterns and dysfunctional behaviors. For many people turning to addictive substances and behaviors is destroying not only their own lives, but damaging their spouse's and children's as well.

In the following chapter we will look at what this writer believes is how God originally planned for the human family to function. We will examine how addictive thinking may have contributed to the fall of humanity from grace and how God has taught us to live a healthy, sober life in the truth.

Chapter Two

A Biblical and Theological Understanding of Marriage and Family and the Impact of Addictions

The previous chapter described the destructive impact of abuse and addiction to substances and behaviors on marriages and families designed by God. Cognitive behavioral theory and therapy was presented as a way which counselors might use in helping clients to heal and enjoy the abundant life God wishes for us. In this chapter a biblical understanding of God's design for humans and their families will be presented. The writer's understanding of God's desire for humans when he created them, where we went astray, and the healing process will be described.

God's Plan

The model God sets before us is the ultimate example of a well functioning, productive, healthy family system. In God we find three distinct persons, the Trinity, functioning together as one. The Father, the Son, and the Holy Spirit each have a role to play, and they work together in perfect harmony.

In Genesis 1 v.2, we find the Spirit of God hovering over the formless mass cloaked in darkness. We do not know the function of the Spirit at that moment; however, we do

see that the creation was an act of God, not just the Holy Spirit acting alone. Verse 3 tells us, "Then God said 'Let there be light' and there was light." The following narrative consistently gives credit for the creation to God; not just to the Father, or the Son, or the Holy Spirit. We are told that all was good. The plan was perfected.

We do not know which person of the Trinity did what in the creation. It appears to this writer that this is the perfect example of a family system working together. We must assume that each member of the Trinity relied on the other to do his part. Each member communicated well with the others. They were aware of their own roles and limitations as individual members of the Trinity. Together they were omnipotent as God. They did not appear to try to take over the other's role or responsibility. Each knew when to be submissive to the other and was willing to step to the front or to the back as was needed to fulfill God's purpose and plan.

In the New Testament, The Gospel of John 1 v.1 tells us:

> In the beginning the Word already existed. He was with God and he was God. He created everything there is. Nothing exists that he didn't make. Life itself was in him, and this life gives light to everyone. The light shines through the darkness, and the darkness can never extinguish it.

The Son, or the Word, was willing to submit himself to the pain and degradation of becoming fully human in order to make it possible for other human beings to restore their relationship with God. He descended from heaven to earth to suffer the humiliating and painful death on the cross.

While the son was on earth, we have clear examples that the he continued to rely on the other members of the Trinity to guide and help him. The New Testament Gospels relate the story of the baptism of Jesus in which he submitted himself to be baptized by John, a human being who had been sent by God before the Son became human, to prepare the way for his ministry. When the baptism occurred, we are told in the Gospels of Matthew, Mark, Luke, and John that the Holy Spirit appeared in the form of a dove and the voice of the Father, acknowledging his love and pride in the Son was heard. Throughout his ministry on earth, Jesus Christ relied on the Father and the Holy Spirit to guide and strengthen him. The Holy Spirit empowered him during the forty days of temptation after his baptism. The Son constantly went to pray to the Father for guidance. The ultimate example would be found in the Garden of Gethsemane when the Son, fully human and fully God, was experiencing fear, knowing what pain he was about to

suffer. He asked if there was a less painful way for the purpose to be accomplished, but then he submitted to the will of the Father for the good of the people.

What this writer sees in the model for the family and for individuals as set before us by God's example is that we are to depend on him first and then on each other. Genesis 1:26-31 tells us:

> Then God said 'Let us make people in our image, to be like ourselves. They will be masters over all life- the fish in the sea, the birds in the sky, and all the livestock, wild animals, and small animals.' So God created people in his own image; God patterned them after himself; male and female he created them. God blessed them and told them, 'Multiply and fill the earth and subdue it. Be masters over the fish and birds and all the animals.' And God said, 'Look! I have given you the seed-bearing plants throughout the earth and all the fruit trees for your food.

The creation story continues to teach us about God's love and purpose for our lives. After God made man, he placed him in the Garden of Eden where God had placed trees which would produce fruit that would provide for most of the man's needs. "At the center of the garden he placed the tree of life and the tree of the knowledge of good and evil" (Gen. 2:9). We learn that God gave man work to do; to tend the garden. This is what appears to be the first covenant. The Lord promised Adam that he would have abundant life, forever in the garden, if Adam would tend it

and not eat from the tree of the knowledge of good and evil. The Lord God saw that it was not good for Adam to be alone and created woman as a companion who would be a helper to him. A female who was equal to him and whose attributes were complementary to his. A human male alone could not be fruitful and multiply. They were united into one with each other and God. As long as they kept the covenant and were dependent first on God and then each other, all their needs would be met. They all had work to do; God and the humans. God's promise to them was that as long as they were willing to do their share, keep their part of the covenant, they would live. They would receive his blessing. They were without pain, emotional or physical. But they were human. God is Spirit.

In Genesis 3, we learn that human beings are imperfect, unlike God. Even though provisions were made for all their needs, Adam and Eve wanted more. The serpent tempted them with the idea that if they ate of the fruit of the tree of the knowledge of good and evil they would become just like God, knowing everything. It is the understanding of this author that this means that they thought they would be all powerful, controlling their own destiny, no longer depending on God. They seem to have

wanted to live forever relying only on themselves and the fruit.

This would be the first instance of substance abuse. Adam and Eve turned to a substance, the fruit of the tree, instead of God to meet their needs. The fruit became a false god. God immediately responded with consequences. The covenant was broken and the blessings were removed. Adam and Eve were banned from the Garden and destined to suffer pain, both physical and emotional because of their human desire for more power.

God had designed the human family to function as his own. We were made in the image of God, spiritually not physically, to rely first on God and then on each other. This writer has concluded that that is another form of the Trinity. Husband and wife are to leave their fathers and mothers and cleave to each other and to God. Tragically, humans brought suffering on themselves by trying to be God. Genesis 3:22 tells us "Then the Lord God said the people have become as we are, knowing everything both good and evil. What if they eat from the tree of life? Then they will live forever." That was not God's plan. The humans were not doing their part.

In terms of Christian counseling, we can see that God also implemented the first perfect treatment plan. He did what he said he would do. Adam and Eve were not allowed to live in denial. They were not allowed to return to the substance. God did not kill them physically, but the life of blessings in the Garden was removed. They were banished from the garden, and guards were established to keep them from returning. It appears that Adam and Eve learned from the experience and from then on turned to the Lord God. Their son, Cain, did not follow. He seems to have thought he could get by with giving God less than was required. Abel gave God what he asked for. Cain was seeking the blessings without doing his part and became jealous and killed his brother. God again provided consequences.

Human beings continued to turn away from God. Genesis 6 informs us that men had begun to turn to sex as a source of comfort "...the sons of God saw the beautiful women of the human race and took any they wanted as their wives. Then the Lord said 'My Spirit will not put up with humans for such a long time, for they are only mortal flesh. In the future, they will live no more than 120 years" (Genesis 6:3). Humans continued to turn away from God, to false gods. Genesis 6:5-8 tells us:

> Now the Lord observed the extent of the people's wickedness, and he saw that all their thoughts were consistently and totally evil. So the Lord was sorry he had ever made them. It broke his heart. And the Lord said, 'I will completely wipe out the human race that I have created. I am sorry I ever made them.' But Noah found favor with the Lord.

From this writer's view we see a loving God who created human beings and provided for their every need. All he required was that they obey him, follow his teaching, and do what was in their best interest. He would be glorified by their praise and worship of him. God would be God and people would turn to him in prayer and worship, and he would bless them according to his plan and purposes. Humans were given a free will to choose to follow him, and most did not. They wanted to be God, knowing everything, not suffering, and seeking instant gratification for their human desires.

Noah submitted to God's command. We are told that he found favor with God. God made another covenant with Noah and his descendants. Sometime soon after the flood, we learn that Noah himself got drunk and passed out in his tent. We learn that his son Ham "saw" his father naked. One theory put forth is that Ham had some kind of perverted sexual contact with his drunken father (Old Testament class note D.Stuart). In any case, humans had begun again to turn

to substances and behaviors to gratify themselves rather than to God.

Time after time in the Old Testament narratives we find humans turning away from the true God to the false gods of alcohol, sex, and the worshiping of wooden images they made themselves. We see stories of men such as David, whom God identified as being after his own heart, turning away from God to have sex with Bathsheba to satisfy his own immediate desires.

After a reading of scripture, one may conclude that human beings as God designed us are ruined. We are essentially impatient, selfish beings. Time after time the people of the Bible would agree to follow God's will, but then choose to turn away when it suited their immediate purposes. They suffered the consequences and at some point turned back to God who forgave them. It is difficult for this writer to believe that God may not have had a hard time keeping his covenant with Noah not to destroy all the people again. We know he got angry and destroyed some. But God is God and he always keeps his word.

Humans do not. And that is the difference. We have made promises to God and to each other which we do not keep. We break our covenant commitments to God and to our

wives or husbands. We seem to want to be all powerful and in control, relying only on our selves and the false gods of money, drugs, alcohol, and addictive behaviors to meet our needs and provide immediate comfort.

How then do we heal from this chronic, distorted, dysfunctional way of living? How do we re-establish our lives so that we have the kind of life God promises us now and in the future? Certainly we have deserved God's wrath and destruction. What we have received and must turn to is God himself descending to earth from heaven to wash away our guilt with his own blood. We can be saved only by grace and returning to the Truth. The Son came to us as a human being, Jesus Christ. He came for the specific purpose which he knew beforehand. He was submissive, he did his part. The writer of Hebrews 4:15 tells us "This High Priest of ours understands our weaknesses, for he faced all of the same temptations we do, yet he did not sin." As previously stated he relied on the Father and the Holy Spirit while here on earth as human. We are taught he was fully human and fully God.

The human problem seems to be deep in our core belief. We believe that we are capable of becoming God. Assuming that if we rely only on ourselves and the false gods we

make, we will have heaven here on earth. We often hear the words "getting high" to describe an experience of turning to substances or behaviors for comfort rather than to God. We have wanted to "get high", to get to heaven living lies. Jesus "got low" to save us. Coming from heaven to be born as a human being in a cattle stall and dying a painful humiliating death on the cross. It is to him and his words that we must turn if we want the life he promises us.

John 6:35-40 tells us:

> Jesus replied I am the bread of life. No one who comes to me will ever be hungry again. Those who believe in me will never thirst. But you haven't believed in me even though you have seen me. However, those the Father has given me will come to me and I will never reject them. For I have come down from heaven to do the will of God who sent me, not to do what I want. And this is the will of God, that I should not lose even one of all those he has given me, but that I should raise them to eternal life at the last day. For it is my Father's will that all who see his Son and believe in him should have eternal life-that I should raise them at the last day.

As stated above, the abuse of and dependence on substances such as drugs and alcohol and on behaviors such as gambling and sex is destroying individuals and damaging families all over this world. As Christian marriage and family therapists and other helping professionals the challenge is to help those who have not yet discovered that they are in fact not God, not able to manage their own

lives without help, to discover the ..."way, the truth, and the life" (John 15:6). We must become dependent on God. "It is the Spirit who gives eternal life. Human effort accomplishes nothing" (John 6:63). This writer does not believe Jesus is referring to the so called bottled spirits found in liquor stores.

The *Diagnostic and Statistical Manual of Mental Disorders IV-TR* (American Psychiatric Association, 2000) defines Substance Dependence as a "maladaptive pattern of substance use, leading to clinically significant impairment or distress...(American Psychiatric Association, 2000, p. 197)." It goes on to describe characteristics such as (1) tolerance-the need for increased amounts to achieve the same effect (2) persistent desire or unsuccessful efforts to cut down or control the substance (3) a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recovering from its effects (4) important social, occupational, or recreational activities are given up or reduced because of substance use (American Psychiatric Association, p. 197).

Addiction to or dependency on behaviors such as sex, gambling, or shopping has been a difficult subject to reach a consensus on among mental health professionals and the

DSM IV-TR does not classify any. Pathological Gambling and numerous sexual disorders which are treated with medications are not identified as addictions. It is important that the therapist understand these disorders as unhealthy ways of seeking relief from pain and discomfort. The individual is turning to a false god to comfort the pain.

The Spiritual Dynamics of the Change Process

There are many books written by both secular and Christian writers on the healing of individuals and relationships. Theories and programs for the healing of substance and behavioral addictions abound. This writer has read a great many of the books and studied the theories and visited several of the treatment centers over the past 30 years. Almost all the books, theories, and centers had good intentions and some good results. But the treatment failure rate for people who have become dependent on substances and behaviors is incredibly high. Why is that so? What must we as Christian counselors do in order to help those whom we have been blessed to work with heal?

The answer lies in Scripture. We humans have become attached to many different things. We have become so attached to our beliefs that we refuse to let them go even

when the evidence confirms that they are wrong (May, 1988). We believe that alcohol, for instance will make our lives easier, that we deserve or need a drink to relieve the stress. We believe that instead of dealing with a marital conflict, smoking a joint of marijuana will make it ok. We get high. But it is a lie. Because we are afraid, we don't want to let go of the attachments we have held on to for so long. They will lead us to death. As discussed earlier we have been making false gods since the fall of humanity in the Garden of Eden.

This writer was excited and encouraged a few years ago when reading Romans 12. The Apostle Paul writes:

> And so, dear brothers and sisters I plead with you to give your bodies to God. Let them be a living and holy sacrifice-the kind he will accept. When you think of what he has done for you, is this too much to ask? Don't copy the behavior and customs of this world, but let God transform you into a new person by changing the way you think. Then you will know what God wants you to do and you will know how good and pleasing and perfect his will really is (Romans 12:1-2).

In the first chapter of this thesis the writer stated that his chosen theory and model of therapy for treating individuals and families is cognitive-behavioral based primarily on the works of Aaron Beck. Beck's theory and therapy models are successful but not really new. The Apostle Paul's writings two thousand years ago appear to be

the model Beck, knowingly or not, has built on. Paul goes on to warn us to:

> Be honest in your estimate of yourselves, measuring your value by how much faith God has given you. Just as our bodies have many parts and each part has special function, so it is with Christ's body. We are all parts of his one body, and each of us has different work to do. And since we are all one body in Christ, we belong to each other, and each of us needs all the others (Romans 12:3-5).

The Apostle Paul conceptualized the problem and told us what to do and why we should. Cognitive behavioral therapy teaches us how. Paul states that we must change the way we think and to be honest in our estimate of ourselves. This writer understands that to mean that if we are to be transformed into a new person we must know our core beliefs. We must be willing to go deep inside our selves and be willing to change those beliefs which are so dysfunctional. Paul states that he has to die to himself daily. The self will of Adam and Eve led to the fall. Our self will is a result of our distorted core beliefs in cognitive therapy terminology. Our core beliefs lead us to make distorted assumptions which lead us to the automatic thoughts that often lead us to the behavior of turning away from God.

Jesus stated that we must lose our lives in order to find life. He was referring to the dysfunctional life in

which the person and not God is the ultimate reference point. In order to heal ourselves, our marriages, and our families we must be willing to set aside our own desire to be God and learn to enjoy a loving and healthy relationship with God and others. Letting go of the old dysfunctional core beliefs we have become so attached to is a painful experience which is the way to healing. The benefits of that process, which the Apostle Paul describes as dying daily, will be that we may progressively learn to live more fully in truth. Only then will we turn from the false security of our attachments to our beliefs, mood altering substances, behaviors, and objects to God and in turn to our families and others.

Chapter Three

Literature Review

Introduction

There is a vast amount of literature on the field of marriage and family therapy. The range of topics and the number of publications concerning marriages and family life appear to be expanding on a daily basis. Aspects of family life covering the diversity of relationships and lifestyles are being researched and published. This author finds it both encouraging and overwhelming. Encouragement comes from the fact that the importance of the family, the significant impact of the family of origin on the future life of each individual and his or her future offspring, is being recognized. Significant interventions and resources are available to help parents and professionals to recognize potential problems early and to make informed decisions about how to correct them. The author, having been a family counselor for many years, recognizes how little he really knows and finds himself wanting to know more about every aspect of family life, an overwhelming, impossible task.

This particular study deals with one significant detrimental aspect of family life which seems to have been ignored or minimized until the last few years, the impact

of substance and behavioral addictions. The focus of this work is the use of cognitive behavioral family therapy for the healing of substance and behavioral addictions in a Christian context. This model includes intercessory prayer, inner healing prayer, and Scripture.

Publications specifically on the subject of using cognitive behavioral family therapy in the healing of addictions in a Christian context are few if any. The writer has therefore had to rely primarily on secular publications for a foundation on which to build his therapeutic techniques. The writings of Christian therapists and philosophers have been incorporated into both the theory and the therapy of this writer. The Holy Bible informs the entire process.

Organization of the Literature Review

1. The impact of addictions on families.
2. The assessment of family functioning and addictions
3. The healing process: theory, theology, and therapy

The author, as previously stated, has been a practicing marriage and family therapist in a secular setting for many years and has personally observed the significant adverse impact that addictions have on individuals, families, and

the community. These personal observations were confirmed by a number of recently published sources.

Impact of addiction on families

Alcohol Problems in Intimate Relationships: Identification and Intervention. A Guide for Marriage and Family Therapists by Linda J. Roberts and Barbara S. McCrady (2003) is an excellent resource published by The American Association for Marriage and Family Therapy (AAMFT) and The National Institute on Alcohol Abuse and Alcoholism (NIAA). The purpose of the guide is to make marriage and family therapists aware of the significance of the problem and to provide information and screening tools and resources to help assess, select appropriate interventions or utilize referral strategies. The book is concise, balanced and well organized in its approach. The authors point out that there have been misconceptions about "alcoholics" for many years. They state that although the focus has been on the more severe form of alcohol related problems, i.e. alcohol dependence or alcoholism, in fact it represents only a small portion of the entire range of alcohol related problems. "Most drinking problems are of mild to moderate severity and are amenable to relatively brief interventions"(Roberts & McCrady, 2003, p. 1).

The authors encourage therapists and health care providers to recognize the early signs and symptoms of alcohol abuse and dependence so that the problems can be addressed early with a higher chance of success. They provide a clear definition of Alcohol Dependence Disorder and Alcohol Abuse Disorder directly from the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (American Psychiatric Association, 2000) and an excellent discussion of the fact that that there is a continuum of alcohol problems. The writers state that the earlier the therapist assesses for problems and begins treatment, if there are problems, the better.

This book also provides a very helpful discussion of the prevalence of the problem based on statistics furnished by NIAA, based on the 1992 *National Longitudinal Alcohol Epidemiological Survey.*

> Alcohol abuse and alcohol dependence are among the most prevalent mental disorders in the United States. In 1992, 7.4 per cent of U.S. adults aged 18 and older-roughly 14 million Americans – were found to have an alcohol use disorder (alcohol dependence or abuse) (Roberts & McCrady, 2003, p. 3).

The writers encourage all marriage and family therapists to be aware of the significance of the problem and they are careful to warn those who wish to treat alcohol related disorders to be prepared with proper

assessment forms, procedures for making the decisions, and to be trained to properly meet the needs of those they serve. They state that all people over the age of 18 who seek help should be screened for alcohol related problems.

This book presents a significant amount of relevant information regarding the problem of alcohol related disorders. It also presents a series of valid screening tools which the clinician can copy and use in practice. There is a comprehensive list of resources including publications by the National Institutes of Health which are available via their web site, www.niaaa.nih.gov.

This writer believes that every marriage and family therapist, pastor, and other health care providers should have this book and use it. One concern is that this book addresses only alcohol use disorders. It does not discuss any other addictive substance or behavioral disorder. A similar publication including other substances and addictive behaviors would be immensely helpful.

Another publication which this writer found helpful in addressing the problem of alcohol and drug dependence on families from a faith based context is *Core Competencies for Clergy and Other Pastoral Ministers in Addressing Alcohol and Drug Dependence and the Impact on Family*

Members: Substance Abuse and the Family: Defining the Role of the Faith Community published by the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, (SAMHSA) (2004). This is a brief report developed by a panel of experts on seminary education in collaboration with the National Association for Children of Alcoholics and the Johnson Institute. According to the SAMHSA National Survey of Drug Use and Health an estimated 7.7 million persons aged 12 or older need treatment for an illicit drug problem: 18.6 million need treatment for an alcohol problem. Only 1.4 million received treatment during that year at a specialty substance abuse treatment facility (Center for Substance Abuse Treatment, 2004, p.i).

This panel recognized that clergy and pastoral counselors have an array of opportunities to address the problems of alcohol and drug abuse and dependence based on their own positions and should develop a set of core competencies which would provide a framework within which to operate. They agreed that clergy need basic facts about these illnesses and their impact on the individual and family members. Clergy should be knowledgeable about:

- The neurological mechanisms and behavioral manifestations of alcohol and drug dependence
- The effects of alcohol and drugs on cognitive functioning
- The role alcohol or drugs may play in the life of an individual
- The various environmental harms posed by alcohol and drug dependence to families, work places, and society as a whole
- The experience of alcohol and drug dependence; how alcohol or drug use affects the "inner world" of the individual using them and how it can affect family members (Center For Substance Abuse Treatment, 2004, p. ii)

Panelists suggested that clergy should be able to articulate a "theological anthropology" of addiction. They should be able to explain in religious terms how addiction is a barrier to spirituality and how recovery can be achieved. The texts and liturgical practices of each individual faith can serve as important resources in this effort.

The panel emphasized that clergy and other pastoral ministers should be aware of the behavioral manifestations of substance use, abuse, and dependence so that they can be alert to the early observable signs and respond appropriately when the problems begin to surface in the congregation.

Based on this writer's experience, the importance of clergy and other pastoral ministers having a solid basic understanding of addictions and the impact they have on families cannot be overstated. This is especially true when we consider the congregation as a family system as discussed in the writings of Friedman (1985) and Scazzero and Bird (2003). For example a member of the church leadership including the pastor, who suffers from an addiction, can cause significant damage if not addressed quickly and responsibly. The report emphasizes that clergy and other pastoral ministers be informed and that they realize their own limitations. Seminaries, denominational leadership, and other educational institutions are encouraged to increase their training programs in this area.

Neither of the above cited resources addressed the issues and impact of behavioral addictions. The *Diagnostic and Statistical Manual of Mental Disorders -IV-TR*, originally published in 1994 with a text revision in 2000, recognizes Pathological Gambling as an "Impulse-Control Disorder Not Elsewhere Classified". Sexual addiction is not identified as a disorder under any classification. Since 1994 the expansion of the internet has allowed for the

explosive growth of both gambling and pornographic sexually oriented web sites. Legalized gambling is more available and is flourishing in many states. On a recent mission trip to the Mississippi gulf coast to assist hurricane Katrina victims with a group from his church, this writer observed that the gambling casinos are being rebuilt faster than houses. There is a growing body of evidence that pathological gambling and what may previously have been thought of as compulsive sexual behaviors are indeed addictions (Carnes & Adams, 2002). They are not simply moral issues and it is the belief of this writer that it is important for counselors, pastors, and other health care professionals to recognize them as addictions or behaviors which can lead to addiction and treat them appropriately.

In the preface to the book *Clinical Management of Sexual Addiction* (Carnes & Adams, 2002), the authors state:

> Only a few decades ago compulsive sexual behavior was seen primarily as a matter of values and character. There was no conceptualization of sex addiction or compulsion as and illness. Sex had not emerged as a legitimate area of scientific inquiry, despite the efforts of courageous pioneers. The addiction field was still focused on alcoholism and had not even integrated drug dependence as a viable component to most treatment programs. To suggest that sex could be part of the addiction process was far beyond most professionals' paradigms. Even further beyond was how to treat the problem.
> Today a growing body of medical literature documents the existence of sexually compulsive behavior that has

> all the features of addictive illness. There is a coordinated effort involving psychiatry, psychology, addiction medicine, trauma medicine, sexology, and those providing services in a criminal justice setting to have a workable diagnostic framework or nosology around the disorder. Our growing conceptualization has sharply clarified our understanding of major societal issues, including child abuse, sex offending, prostitution, and anonymous sex. Advances in addiction medicine have created a paradigm of understanding that addictions also coexist and interact with one another. Furthermore, the phenomenon of cybersex addiction has underscored how people can literally experience a loss of control over their sexual choices. Finally, the explosion of knowledge from the field of neurochemistry has helped integrate the different conceptual frameworks (Carnes & Adams, p. xi).

In the first chapter entitled, *The Sexual Addiction Assessment Process,* Carnes and Wilson (2002) provide a thorough review of the process for diagnosing sexual addiction. They urge the clinician to be very thorough and cautious in using the term sexual addiction. They are clear that the *DSM IV-TR* does not yet recognize sex addiction as a disorder. They compare the recognized symptoms leading to the diagnoses of alcohol and other drug addictions to behaviorally induced mood enhancing processes such as sex and gambling. The authors state consistent patterns of sexual addiction closely resemble the patterns of alcohol and drug-addicted clients, as well as of compulsive gamblers. Patterns that describe (1) loss of control, as exhibited by a persistent desire or unsuccessful efforts to control or stop behaviors; (2) a continuation of the

behavior despite adverse consequences such as arrests, broken marriages, financial problems; and (3) and obsession or preoccupation with obtaining, using, or recovering from the behavior, all represent probable existence of an addictive process (Carnes & Wilson, p. 5).

In his book *Healing the Wounds of Sexual Addiction* (2004), Mark Laaser writes about the impact of sexual addiction from his personal experience as a counselor and ordained minister who was addicted to sex. Laaser informs us that Christians are not exempt from this disease. "Experts speculate up to 10 percent of the total Christian population in the United States is sexually addicted" (Laaser, p. 15). Laaser cites a survey of pastors in which 40 per cent reported looking at pornography and another study in which two thirds of all Christian men admitted to struggling with pornography (Laaser, p. 15). He does not suggest all these men are sex addicts, only that pornography is readily available and that we are all susceptible to it. He calls for the Body of Christ to stop our judgementalism and to reach out as Jesus did to the Samaritan woman, offering love and help to those who so desperately need the relationship God wants with and for each of us.

Although Pathological Gambling is recognized as a mental illness in the *DSM-IV-TR*, it is defined as an Impulse-Control Disorder Not Elsewhere Classified. The manual states that the data on prevalence is limited and that it may be as high as one to three percent of the adult population. It is interesting to note that in the section on Familial Patterns it states "Pathological Gambling and Alcohol Dependence are both more common among the parents of individuals with Pathological Gambling than among the general population" (American Psychiatric Association, 2000, p. 671). The National Council on Problem Gambling states that people who are problem gamblers are much more likely to suffer from depression and suicide than the general population. They also report that youth and seniors have higher rates of gambling problems than the general population (National Council on Problem Gambling, 2005). Since the original publication of the *DSM-IV* in 1994, a great deal of new evidence to support the belief that gambling addiction does exist has published. The University of Connecticut and Harvard are among the major universities and organizations which are conducting the research. The impact on many families has been financially and emotionally devastating.

In his book, *The Chase: career of the compulsive gambler*, Henry Lesieur (1984), covers many aspects of the problem of compulsive gambling. He devotes the third chapter to describing in some detail the impact on the family.

> Getting married can cause trouble for the gambler. More than half of the married gamblers I interviewed believed that their gambling became worse right after they married....Of course, with increased responsibility and added expenses, it may only have seemed that getting married worsened the situation. When financial crises arise, gambling is often used as an added source of income to help stiffen an already sagging budget. Losses that could be hidden easily when single must now be accounted for in some fashion (Lesieur, p. 60).

As discussed earlier, addictions lead to family problems which often seem to enable the addicted person to turn more to his or her addiction, be it a substance or a behavior, in order to decrease the anxiety. This systemic addictive thinking and behaving process allows the problem to become bigger and bigger. The addicted person turns to a false god that is impotent to solve the problem.

Summary

The above section on the impact of addictions on families has presented a brief overview of the real problem. The point this writer hopes to make is that everyone who counsels people in whatever capacity should be

aware of the impact that addictions have on individuals and families. Addictions are detrimental to our marriages and our children, our churches, and our workplaces. There is evidence that we may not only become addicted to substances like nicotine, alcohol, cocaine, methamphetamine, and marijuana but also to neurochemically-fueled mood altering behaviors, especially gambling and sex. Counselors, pastors, and healthcare professionals must be aware of the impact addictions may be having on their clients, church members, and their families. Substance or behavioral abuse or addiction may not be identified initially as the problem. A full assessment of the individual and the family who seeks counseling must include questions which indicate whether or not there is an abuse or dependence disorder either causing the real problem or which will negatively affect the outcome of therapy.

In their recent book *Modern Psychopathologies: A Comprehensive Christian Appraisal,* Yarhouse, Butman, and McCray (2005) address addictions in chapter seven as "Problems of Social Impact." They state that "from a psychosocial perspective, economic loss is only overshadowed by the strain on families and entire communities affected by destructive patterns of behavior

and the lack of available resources to address such concerns" (Yarhouse et al., 2005, p. 181). The authors cite numerous statistics regarding the numbers of people who are addicted to or abusing substances and behaviors. They state that we have reached a point of crisis in the United States (p.81). Themes in pastoral care are also discussed.

> At a broader theological and pastoral level, substance abuse and dependence or addiction are considered problems because people are created by God for the purpose of relating to him rather than being 'subject to another controlling influence'(Vere, 1995, p.298 quoted in Yarhouse et al., p. 183).

The authors give a brief overview of the different types of addictive substances and behaviors. The importance that the church recognizes the key role it should have in the prevention of substance and other addictive disorders is emphasized. They encourage Christian helping professionals to be aware of stereotypes and myths which may distort their assessments of the individual or family problems. This book is not a how to do treatment or a detailed psychopathology book. It gives an overview of the problem of addictions as well other psychological problems. The various treatments and resources available to the Christian mental health professional are described. This writer believes that this book would be an excellent addition to the library of all pastoral counselors.

Assessment of Family Functioning and Addiction

During these times of "managed behavioral health care" it is very difficult for counselors to have the time to do a complete, comprehensive assessment of clients, whether it is a couple, a family, or an individual. The managed care companies often limit the number of counseling sessions, no matter how serious the problem or problems. Counselors are encouraged to immediately address the "presenting problem", fix it in six counseling sessions, and send clients on their way until their mental health care benefits are renewed in a year or so.

This writer has observed that even in our church settings the time available to counsel those who seek help is very limited. Pastors are very busy. Many if not most pastors seem to believe that substance and behavioral abuse or dependence disorders are simply immoral behaviors and that the individual suffering from one or more of these disorders could stop it with will power when just the opposite is true. The use and abuse of most addictive substances and behaviors may be immoral; however, the person who has become addicted cannot stop it alone. He or she must surrender to God and accept that as the Apostle

Paul teaches us "...when I am weak, then I am strong" (2nd Cor.12:10).

Despite the limitations placed on counseling professionals by the managed care companies, this writer believes that a thorough assessment, case formulation, and treatment plan are absolute essentials to the successful outcome of therapy. As described in the first chapter, cognitive behavioral therapy can be a brief, goal oriented therapy. The major theorists and writers who use cognitive behavioral therapy are in agreement that a thorough assessment, case formulation, clear goals and a warm therapeutic relationship are essentials (Beck, Wright, Newman, & Liese, 1993, Dattilio & Padesky, 1990, Epstein & Baucom, 2002). The difficulty is getting all that done in the time allowed.

Dattilio and Padesky (1990) offer some clear suggestions on how to begin the therapeutic process with couples that were covered in chapter one. The *Clinician's Intake Evaluation for Couples* developed by Aaron Beck is a very helpful form for intake purposes. In addition their book suggests that the counselor may wish to use several other written surveys and questionnaires which will assist in making a more accurate diagnosis and development of a

treatment plan. Some of these are: *Marital Attitude Questionnaire-Revised* (Pretzer, Fleming, & Epstien, 1983), *Dyadic Adjustment Scale* (Spainer, 1976), and the *Marital Satisfaction Inventory* (Snyder, 1981). They indicate these forms have all been empirically validated to assist the therapist in making an accurate diagnosis. Other tools developed by Aaron Beck which are recommended are *Beliefs About Change Questionnaire* and *Problems in Style of Communication*. The authors point out that using these types of questionnaires early on will assist the therapist in assessing how the couples work together initially and may be used later in therapy to assess progress. The use of more extensive psychological testing such as the *Minnesota Multiphasic Personality Inventory-2*, if indicated, is encouraged to assess for individual psychopathology.

This particular research project has focused on the use of cognitive behavioral therapy with families affected by addiction. The author concurs with Roberts and McCrady (2003) that in addition to the use of the forms and questionnaires mentioned previously the therapist should screen every adult patient for substance and behavioral addictions. Roberts and McCrady (2003 p.A-1) offer suggestions and evaluations of several screening tools

which can be used effectively to indicate whether further assessment for alcohol abuse or dependence is needed.

Gamblers Anonymous provides *The 20 Questions of Gamblers Anonymous,* a brief questionnaire which can be used if there is any indication of a gambling problem. It is free and readily available in their literature and on their website. The *South Oaks Gambling Screen* (South Oaks Foundation © 1992) is a more extensive diagnostic tool which has been researched and validated for accuracy in diagnosing pathological gambling (Lesieur, 1999 p.18-20).

Carnes and Adams (2002 p.11-12) provide a *Sexual Addiction Screening Test* or *SAST* (Carnes, 1989) and extensive diagnosis and treatment guidelines for the sexually addicted person and the family. The *SAST* is available in versions for heterosexual men and women and for homosexual men. It is available free on the website *www.sexhelp.com*.

Genograms: Assessment and Intervention (McGoldrick, Gerson, & Shellenberger, (1999) is a book which this writer has found to be helpful. The development of a family genogram helps the patient or patients to see a picture of their families of origin. Cognitive behavioral theory holds that we develop our core beliefs and ways of dealing with

life based on what we learn and experience primarily in our family of origin. It is especially helpful for couples who are dealing with substance and behavioral addictions of any type to see the significant impact the dysfunction of their families had on them. It is also helpful in alleviating the guilt and shame many addicts feel. When they can understand that there is a family history of substance dependency, sexual addiction, or codependency, and that their dysfunctional beliefs, ways of thinking and dealing with life were learned and can be changed, they tend to feel more hope. Cognitive theory states that if the patient does not believe change is possible, he or she will not.

In the *Handbook of Relational Diagnosis and Dysfunctional Family Patterns* (1996), Chapter 29 "Substance Abuse and Addictive Personality Disorders", Williams (1996, p. 448-462) provides an interesting and helpful discussion of substance abuse and addictive personalities. Williams is clear that the *DSM-IV* does not recognize "addictive personality" as a disorder. He does discuss his personal observations of behaviors and attitudes that are almost universal in alcoholics/addicts who present for treatment.

> These include impatience, impulsivity, emotional immaturity for their developmental and chronological age, superficial sense of entitlement, grandiosity, false sense of control, intolerance for dysphoric

> mood, self deception, and, of course, the defense mechanisms of denial, rationalization, projection, and minimization. Additionally, the addict exhibits a distorted view of adult living, usually shunning responsibilities, seeking a caretaker, lying regarding drug-using habits-and often other areas of his or her life-unavailability for interpersonal nurturing and intimacy, and emotional isolation (Williams, 1996, p. 451).

Williams provides the reader with an overview of how the addictive family system works and the importance of the problem being recognized as a family system problem which is best treated by engaging the addict and family members in long-term treatment.

This writer believes the contribution by Williams (1996) is valuable because it describes some of the family dynamics which might assist a therapist or pastoral counselor with making a more accurate assessment of the problem. Clues to dysfunctional parenting patterns which may be a result of addiction can be observed in children before either of the parents are seen by the therapist.

Summary

This section has stated this writer's belief that a complete a complete assessment, including one for substance and behavioral addictions, for every patient or family a counselor sees is vital to a positive outcome. This standard is a difficult task in light of today's managed health care industry's rules and regulations. Several

"tools" which are taken from cognitive behavioral therapy and addictions counseling were offered. There are other good ones available. The important point is that as a counseling professional or pastoral counselor one is obligated to be aware of the resources available to help the whole person and his or her family. The counselor must also be prepared through training to use the tools available for assessment and to know his or her own skills and limitations when addictions are diagnosed.

The Healing Process: Theory, Theology and Therapy

Many books are available on how to counsel people and families. This writer has worked as a marriage and family therapist in secular settings for many years. Hundreds of books and journals have been read and many seminars attended.

Despite all the reading and training there was a sense that there must be something more to this work. The following section will cover some of the resources this writer has found. Training in a nominally Christian university had encouraged the writer to leave God out of the therapy room. No work setting allowed discussions of spirituality. The healing power of God was ignored. He was

there and available all of the time. The writer was ignoring him and the writer's work was suffering.

The classic reference work in addictions counseling is *Alcoholics Anonymous* (Alcoholics Anonymous, 2001). This book, commonly called "the big book," is primarily the story of two men, Dr. Bob and Bill W., who developed the twelve step program which has been successful in helping thousands of men and women to recover from alcohol dependency. It describes how they came together in their search for healing and how, based on the Bible they developed the twelve step model which is used today. The Twelve Steps are used not only for people with alcohol dependency but also for the healing of all of the other addictions of which this writer is aware. "Without help it is too much for us. But there is One who has all power-that One is God" (Alcoholics Anonymous, 2001, p. 59).

The first, and in the opinion of this writer the most difficult, step is: "We admitted we were powerless of alcohol-that our lives had become unmanageable." In cognitive behavioral terms that means that one must look deep down inside oneself and recognize that in truth one has turned to false gods to numb pain. The addicted person must fully understand that he or she has held on the

distorted core belief that, in spite of all the evidence, he or she alone could control use of the drug or behavior.

The second step is: "We came to believe that a Power greater than our selves could restore us to sanity."

The third step is: "We made a decision to turn our lives over to God *as we understood him* (Alcoholics Anonymous, p. 59). This step is where the power of healing is found and where Alcoholics Anonymous also errs. They watered the truth down and made it "God *of our understanding*". That statement is ambiguous and misleading in the sense that the alcoholic and other addicted individuals tend to make a false god of almost anything. Bill W. was probably also addicted to sex according to Patrick Carnes. He was known to have numerous extramarital affairs after he stopped drinking. Carnes states a former mistress receives a portion of the royalties from the sales of *Alcoholics Anonymous* today. (Seminar: Facing the shadow of sexual addiction. December 2005). With the caveat that God is God, there is no other and that if we understood Him we would be God, this writer believes that this book has a great deal to offer and should be read by everyone who suffers from any addiction as well as those in the counseling professions. The paradoxical theme of true

healing found in 2nd Corinthians 12:9-10 is brought to light in this work. The Apostle Paul related to the people of Corinth that he had been in great pain:

> Three different times I begged the Lord to take it away. Each time he said, "My gracious favor is all you need. My power works best in your weakness." So now I am glad to boast about my weaknesses, so that the power of Christ may work through me. Since I know it is all for Christ's good, I am quite content with my weaknesses and with insults, hardships, persecutions, and calamities. For when I am weak, then I am strong.

The truth spoken by the Apostle Paul 2000 years ago helped this writer to understand that the only way true healing happens is through surrender to God. It is not only the person who has the addiction who must surrender, but the therapist, family members and perhaps their pastor as well. Only by admitting our own weaknesses, surrendering, and seeking help do we receive healing.

Dallas Willard in his book *Renovation of the Heart: Putting on the Character of Christ* (Willard, 2002 p.9) affirms that true healing comes from Christ and that it is only through Spiritual Transformation that we will be healed. Willard reminds us that Jesus said that those who give themselves to him will receive "living water: the Spirit of God Himself that will keep them from ever again being thirsty-being driven and ruled by unsatisfied

desires-and that this water will become a well or spring gushing up to eternal life(John 4:14)."

> He invites us to leave our burdensome ways of heavy labor-especially the religious ones- and step into the yoke of training with him. This is a way of gentleness n and lowliness, a way of soul rest. It is a way of inner transformation that proves pulling his load and carrying his burden with him to be a life that is easy and light (Matthew 11:28-30). The perceived distance and difficulty of entering fully into the divine world and its life is due entirely to our failure to understand that "the way in" is the way of persuasive inner transformation and to our failure to take the small steps that quietly and certainly lead to it (Willard, 2002, p. 10-11).

This writer understands the above to mean that in our own human distorted thinking and belief systems we have made life too hard. We have turned from the truth of the word of God which will give us abundant life to the lies promised by the false gods which will in fact destroy individuals and families.

According to Willard:

> The human spirit is an inescapable, fundamental aspect of every human being; and it takes on whichever character it has from the experiences and the choices we have lived through or made in our past. That is what it means to be formed.
> Our life and how we find the world now and in the future is, almost totally, a simple result of what we have become in the depths of our being-in our spirit, will, or heart. From there we see our world and interpret reality. From there we make our choices, break forth in action, and try to change our world. We live from our depths-most of which we do not understand (Willard, 2002, p. 13).

Willard is a theologian and philosopher. He has stated clearly in Christian terms the foundations and principles on which cognitive behavioral theory and therapy are built. He addressed the special area of addictions. The healing process is simple. We must turn from the lies which the false idols of addictive substances and behaviors promise us to the truth of the Living Waters of the Holy Spirit. As Christian counselors, our responsibility is to assist our patients with this process. Willard suggests that this change comes from a revolution of character, which proceeds by changing from the inside, from the core, through ongoing personal relationship to God in Christ and to one another. This writer believes that Willard is emphasizing one of the basic fundamentals of cognitive behavioral therapy- that the establishment of a genuine, warm, caring therapeutic relationship with each person with whom we counsel is essential. As Christian counselors we represent Christ. How we relate to those who also need him is a critical part of the journey. For healing to begin, our clients must see Christ in us. We must learn to attract them as he did.

The importance of understanding healthy family systems is discussed:

> T.S. Elliot once described the current human endeavor as that of finding a system of order so perfect that we will not have to be good. The Way of Jesus tells us, by contrast, that any number of systems-not all to be sure-will work well if we are genuinely good . The importance of "systems" is a main reason why Jesus did not send his students out to start governments or even churches as we know them today, which always strongly convey some elements of a human system. They were, instead to establish beachheads of his person, word, and power in the midst of a failing and futile humanity. They were to bring the presence of the kingdom and its King into every corner of human life simply by fully living in the kingdom with him (Willard, 2002, p. 15).

As Christ's disciples, counselors must understand what healthy family systems are and establish healthy relationships with their clients which will inspire them to learn and live in truth.

In Chapter 5, *Radical Evil In The Ruined Soul*, Willard presents a description of how powerful addictive thinking really is. He states "God being God offends human pride. If God is running the universe, humans are not (Willard, 2002, p. 52). The Twelve Steps of Alcoholics Anonymous require that the person acknowledge his own powerlessness and surrender to God. It appears to this writer that many of us have difficulty with understanding the difference between being made in the image of God and being God.

One of the most powerful and relevant discussions regarding addictions in Willard's book is on denial. Denial

has long been recognized as key component of addictive thinking. Willard (2002, p. 52) states:

> Denial of reality is a capacity inseparable from the human will as we know it, and it has its greatest power when it operates without being recognized as such. (Of course by "denial" we mean to include not only the rejection of what is the case, but also affirmation of what is not the case.

In a world apart from God, the power of denial is absolutely essential if life is to proceed. The will or spirit cannot-psychologically cannot- sustain itself for any length of time in the face of what it clearly acknowledges to be the case. Therefore it must deny and evade and delude itself.

Willard goes on to suggest that when the truth that God is God is put into the human heart there will be a struggle to accept it because we have believed for so long that man is God and when that belief has not worked to relieve our pain we have created gods from wood. This writer would add substances and behaviors. Cognitive behavioral theory holds that it is in making changes in our deepest inner being, our core beliefs that true long term healing starts. Cognitive behavioral theory and therapy are relatively simple elegant tools which are entirely consistent with Scripture and can be used by a therapist to assist the people who come for healing to confront their

denial and live in the truth. Neither cognitive behavioral therapy nor the Bible says it will be easy.

The Apostle Paul tells us in Romans 12:1-2:

> And so dear brothers and sisters, I plead with you to give your bodies to God. Let them be a living and holy sacrifice-the kind he will accept. When you think of what he has done for you, is this too much to ask? Don't copy the behavior and customs of this world, but let God transform you into a new person by changing the way you think. Then you will know what God wants you to do and you will know how good and pleasing and perfect his will really is.

Willard (2002, p. 193) describes the healing of human relationships and especially marriage:

> If that relationship is wrong, all who come through it will be seriously damaged. And they will be further damaged by a surrounding world of similarly damaged people who are trying to manage their ways of being together on the assumption that assault and withdrawal are just "the facts of life." Consequently, spiritual formation, and all our efforts as Christians to minister to people, must focus on this humanly most central relationship.

We must turn from the lies we have believed and acted upon to Christ. There are no human answers to human problems. Willard's book has had a powerful impact on this writer's personal and professional life. Marriage and family therapists have an important role to play in the healing of the Body of Christ. It becomes even more challenging when dealing with families who are affected by

addictions. Willard's words remind us that we are not alone and we must keep that in mind when we are doing our work.

Intercessory and inner healing prayer

One of the criticisms often heard by this writer regarding cognitive behavioral therapy is that it seems to be so secular in its approach to healing. This writer understands that it can be used that way, and that there is evidence that it will work to some extent. The early training and most of the work of this writer was from a secular approach. God was not invited into the therapy or the therapy room.

As stated previously this author knew there was something missing in the work and at times became burned out and disgusted. Several years ago, after an automobile wreck in which the writer and his family suffered some severe physical injuries, the pastor of his church introduced the power of prayer for healing. One of the reasons stated in the first chapter of this thesis that the writer prefers the cognitive behavioral model of psychotherapy is that it is consistent with the teachings of the Holy Bible.

The book of James 5:13-15 teaches us to keep on praying when we are suffering as well as when we have

reason to be thankful. We are encouraged to ask others to pray over us for healing:

> Are any among you sick? They should call for the elders of the church and have them pray over them, anointing them with oil in the name of the Lord. And their prayer offered in faith will heal the sick, and the Lord will make them well. And anyone who has committed sins will be forgiven.

In his book *Healing* (1999), Francis McNutt provides a comprehensive discussion of intercessory prayer for healing of illnesses and inner healing prayer. McNutt gives a brief history of intercessory prayer, praying for the healing of others. He devotes Chapter 13 to *The Inner Healing of Our Emotional Disorders.*

McNutt readily recognizes that it is difficult to prove scientifically that when people intercede with God by praying for the healing of a person suffering from an illness it is difficult to prove that the prayers played any factor if the person gets well. He cites the work of Larry Dossey, M.D. who has published several books describing medical research studies which indicate that prayer has a significant effect. Dossey questions whether we might reach a point where physicians who ignore prayer could be sued for malpractice (Dossey, L., 1996, *Prayer is Good Medicine*, San Francisco, Harper pp.66-67 quoted in McNutt (p. 19).

McNutt discusses the fact that not everyone who is prayed for receives healing. There are many factors involved: God's will, the availability of good medical care, and the sick person's willingness to cooperate with medical care provided for him or her are among the variables.

Prayer for inner healing for emotional disorders is suggested for those who seem to be held down by past traumatic experiences. Inner healing prayer is described as asking Jesus Christ to walk with us back to the time we were hurt and to free us from the effects of that wound in the present.

This involves two things:

1) *Bringing to light* the things that have hurt us. Usually this is best done with another person; even the talking out of the problem is in itself part of the healing process.

2) *Praying* to ask the Lord to heal the binding effects of the hurtful incidents of the past (McNutt, 1999, p. 147).

This book was one of the first on this subject and has been considered the classic reference work. McNutt is a former Roman Catholic Priest. He obviously believes in the

healing power of prayer. He also balances his discussion of it with the fact that sometimes God grants the prayers and sometimes not. We are not God and will never fully understand his ways.

In the design of this project, as an integral part of the therapy, intercessory prayer by a prayer team at the church that the writer and the client family attend will be done. We will also include prayer for inner healing. Cognitive behavioral therapy holds that at the root of our dysfunctional ways of thinking and behaving are distorted core beliefs which were formed in us usually as children. These beliefs are often based on misinterpretations of traumatic events and their meaning about us. Inner healing prayer is a way to go back to those events and to get to the truth by asking the Lord to help us. The therapist and the client then use what is revealed to replace the old distorted core beliefs, dysfunctional thoughts and behaviors with true, more functional ways of believing, thinking and behaving. We turn to God for truth and he provides tools to help us put that into practice.

In a research article entitled *Secular Versus Christian Inpatient Cognitive-Behavioral Therapy Programs: Impact Depression and Spiritual Well-Being* (Hawkins, Tan, &

Turk, 1999) the authors affirm the value of using cognitive behavioral therapy with Christian clients for the treatment of depression. They describe some of the characteristics of Christian therapies that can be easily adapted into the cognitive behavioral framework. Those characteristics include reliance on Scripture as the primary truth, seeking wholeness through God, and acknowledging factors that are important in a Christian context.

The use of techniques such as Scripture memory, meditation, personal prayer, intercessory prayer, and inner healing prayer are suggested.

This study confirmed that cognitive behavioral therapy can be adapted to a Christian context in dealing with depression. This writer has made an effort to adapt it into helping people who have become dependent on substances and behaviors. Hawkins, Tan, and Turk (1999) state that two important elements in the healing process are the establishment of values and the relationship that the therapist establishes with the client, including the client's family members. They affirm as do Beck, Wright, Newman, and Liese (1993) that the value the client places on healing is a key to a successful outcome. As the client's values change, significant cognitive, emotional,

spiritual, and behavioral changes are more likely. Hawkins et al. (1999) also agree with Beck et al. (1993) that cognitive behavioral therapy is not defined by just a set of techniques. The warm, collaborative, environment, the relationship which the therapist establishes with the client is a key element of the theory and therapy of Beck et al. (1993). In this article, Hawkins et al. (1999) suggest that it is the relationship between the client and therapist and enhanced by Christ's unconditional love.

Concluding Thoughts

This purpose of this literature review has been to bring to the awareness of the reader that substance and behavioral addictions do exist and that they have a significant detrimental impact on our families and our future generations. The Christian church and Christian counselors have a significant role to play in the healing that must happen. The church must stop living in denial, pretending that addictions are not a real problem or that they are simply moral issues. This literature review has covered some of the material that this writer has found helpful in developing a way of counseling individuals and families who suffer from addictions.

The literature review included material which this writer believes confirms that the problems caused by addictions to substances and behaviors are growing. Literature which confirms this writer's belief that behavioral addictions do exist and that they should be recognized as such was presented.

This writer described in detail the cognitive behavioral therapy of addictions in the first chapter of this dissertation. This chapter has included material which has been found by the author to be consistent with the Scriptures and cognitive behavioral theory and therapy.

As all the writers in this review concluded, the most important element in the healing process is not a set of techniques. Most critical is the relationship which a skilled therapist, enhanced by the power of the Holy Spirit, develops with the client.

Chapter Four

A Case Study of a Family Affected by Addiction

Introduction

This chapter will present the story of a family significantly impacted in a detrimental way by addictions. This family is a Christian family. They are members of the writer's church and were referred for counseling by the senior pastor.

A brief history, including the family of origin of the husband and wife will be described. Assessment of the current marital condition using the Locke-Wallace Marital Adjustment Test and the Enrich Marital Inventory will be included. A Genogram will be done. A comprehensive treatment plan based on a Christian cognitive behavioral model of treating families affected by addictions will be developed.

In order to insure confidentiality, the names of all family members have been changed. The daughter whose behavior triggered the father's anger outburst which led to the referral was away at college most of the time and was not available for most of the counseling sessions.

Presenting Problem

John was referred for counseling by the senior pastor of our church after John had consulted him about a problem he was having with his wife Alice. John had recently discovered their 18-year-old daughter having sex with her boyfriend in their house. John became very angry and a minor physical altercation ensued. The atmosphere at the house between John, his daughter, and his wife has become very tense. John does not consider himself to be angry. The daughter, Mary, has enrolled in a state university and is now away from home during the week. She continues to come home on weekends and to see the boy. John says he is angry with the boy but not his wife or daughter. Alice is fearful that he will drive Mary away; that she will not want to come home at all. He says he is afraid Mary will get pregnant, end up dropping out of college, and marrying a "redneck Bigelow boy." Alice resents that statement because she grew up in Bigelow.

After three counseling sessions, two individual and one with Alice, John agreed that he has a problem with his anger that is hurting both his marriage and his relationship with his daughter. We decided to proceed with

marriage counseling first and then to include Mary when she was available. Alice agreed.

John's History

John is a 58 year old Caucasian. He is 5'8" tall and weighs 198 pounds. He takes medications for allergies and emphysema which was diagnosed in March of 2005. He says he has cut back on smoking cigarettes. He exercises regularly at a local fitness center. He is employed as a manager for a department of state government and has a part time job selling real estate mortgages by phone at night.

John was born in 1954 in Houston, Texas. He is the youngest child and only son of his parents. One sister, Nancy, is 73 years old and one sister, Katherine, was killed in an automobile accident in 1965 when she was 23 years old and John was eleven. His father was a building contractor who died one year later at age 63 from emphysema. He was a recovering alcoholic. John remembers him as being sick a lot. He was not close to him emotionally. His mother remarried two years later. His stepfather was an orthopedic surgeon who was not home much. John describes their relationship as distant and conflicted.

John was sexually molested at the age of six by a neighbor boy who was sixteen at the time. John says that he thought the relationship was special, and he did not tell anyone. The sexually abusive relationship continued for about seven years. John began smoking marijuana at age thirteen. He soon began drinking alcohol and using other drugs which he stole from his stepfather's clinic. He also sold the drugs at school.

At age fifteen, John was suspended for fighting from the private school which he attended. He was sent to the family's Episcopal priest for counseling. John eventually told the priest about the sexual abuse and his concern that he might be homosexual. The priest assured him that he was not. The priest developed a close relationship with John and occasionally hired him to baby sit his children when he and his wife were away from home. On one weekend, when John was hired to stay overnight, John awoke to find that the priest had returned home and was in bed with John, attempting to perform oral sex on him.

John soon dropped out of school and left home. He began to live a homosexual, drug dependent life. His parents found him and sent him to live in a small town in Mississippi with his older sister, an attorney, and her

husband, a physician. John continued to be rebellious but finished high school and moved to Memphis, Tennessee, to attend college. He continued to live as a homosexual and abuse alcohol and other drugs.

John dropped out of college and moved back to Texas to live for a while. He attended college there but primarily focused on partying. He dropped out of college and moved back to Memphis where he got a job in building supplies sales. He did well in his job, continuing to drink, use drugs, and party at night. He would occasionally "pick up" men on the street.

In 1974 John was transferred to Little Rock, Arkansas, where he continued to do well at work and spend most of his money on alcohol and other drugs. He had begun to have sexual relationships with both men and women by this time. He was using a lot of cocaine. He started his own building supplies business in 1976.

John had two "long term" relationships. One was with a man, Dub, lasting for one year and another with a woman, Marsha, for three years. Both were centered around drugs and partying. Marsha was the daughter of a very prominent local minister.

In 1979 John had a “conversion” experience. He was high on cocaine in a hot tub with a group of friends. He states he clearly sensed the presence of Jesus and was told that he was loved and that he did not need to use cocaine anymore. He committed to become celibate and to do whatever the Lord led him to do. He continued to drink alcohol and smoke marijuana. He states he only used cocaine one time after that. John returned to the Episcopal Church where he became very active. He moved to a rural area to live alone. He was committed to celibacy. He sought counseling from priests and mental health professionals to heal his wounds from the past. He never quit drinking alcohol and smoking cigarettes. John states that no one ever told him he should.

In 1980, John met Alice and her husband Darrell, who ran a small grocery store close to his house. They became good friends, visiting when John would stop by the store after work.

Darrell was also an alcoholic. He was killed in a car wreck in 1981, after he had been drinking. Alice was following in the car behind him. She was understandably traumatized by the event. Her mother moved in with her to help care for the children. Alice continued to run the

grocery store. John dropped by more often, and their friendship grew over time.

Alice's History

Alice is a 53 year old Caucasian female. She is 5'5" tall and weighs 185 pounds. She was born in 1951 in a small town in Arkansas. She was the second child and first daughter of her parents. She has a brother 58, a sister 48, and a brother 45 years old. All siblings are still living. Her father died in 1976. Her mother lives close to her now. She may soon be living with them due to poor health.

Alice's father was an abusive alcoholic. She remembers seeing him abusing her mother and older brother on many occasions. She denies that he abused her in any way. Her father was a farmer whom she describes as very hard working. Her home life was chaotic. She describes her role as a peacemaker and the rescuer of her mother and brother.

At sixteen Alice got pregnant and married Craig. She says she realizes now that she did that just to get away from the stress at home. Craig became abusive soon after the marriage. He did not drink or use other drugs. Their daughter, Charlotte, was born in 1969. Alice divorced Craig in 1971. She met and married Darrell, a "nice" man 10 years older than herself in 1972. He adopted Charlotte and they

had a daughter, Kim, in 1974. Alice describes that marriage as difficult at times, but she had two children and he did not abuse her. He drank a lot of alcohol which she thought was normal for men to do. She was emotionally and financially dependent on him.

After Darrell's death, Alice had a very difficult time. John's friendship meant a great deal to her. As they began to fall in love, John told her most of the history of his past. He says he wanted her to know "what she was getting." John had become very involved in the church which she thought was good.

Marital History

They married in 1984. They lived in Alice's home near Little Rock for a while and then decided to move to Bigelow, Arkansas, thirty five miles away, where Alice grew up. They purchased her grandmother's "home place" and remodeled it.

John's relationship with his stepdaughters was difficult from the beginning. He states he wanted only the best for them. He had never been a parent before. These two girls, Charlotte 15, and Kim 8, had been through some rough times emotionally and did not want him coming in to "run" their lives. Charlotte had begun to experiment with

marijuana and not do well in school. John saw her as going down the same path he did, and he wanted to prevent it. Alice was caught again in the role of peacemaker, pulled between her husband and daughters.

Mary was born to John and Alice in 1986. They continued to attend church and be involved in different ministries. He eventually completed his college degree while working full time and got a management job with a large corporation in the area. Alice became a licensed massage therapist and worked for a local chiropractor. Mary did very well in school. She was good in both academics and athletics. John continued to try to help Charlotte and Kim see the error of their ways. So the conflict continued. He continued to drink excessively. Alice, having been raised in an alcoholic home, thought it was normal, but she did not like it when John often drank to excess and embarrassed her around their friends.

In 1992 Charlotte died from cancer. She was twenty-three years old. Her fight against cancer was a difficult one for the entire family. John says that his relationship with her had begun to heal just prior to the diagnosis in 1991. The experience of their struggle to fight the cancer

brought the family closer. John states that he and Charlotte had a good relationship at the time of her death.

Alice had now lost a daughter and a husband. They continued their church work and got involved in several ministries. John began to work in a prison ministry. He continued to drink excessively.

John and Alice joined Saint Andrew's Church in Little Rock, Arkansas, soon after it had been formed. John was asked to serve on the Vestry three months later.

Mary became the somewhat "perfect child." She did well in academics and excelled in sports at school. She served in several youth leadership positions at church. She was John's "superstar." Kim married and moved to Texas. Her marriage is currently very troubled. She has two children. Alice is deeply worried about her. John says Alice wants Kim to move back to Bigelow. Alice denies that, but she does miss her very much.

John was laid off from his well paying corporate job in 2002, due to a general corporate downsizing. Mary was still in high school, and he wanted her to attend college. He does not like the boys in the small town they live in, and he wanted her out of it. He was out of work for almost two years. He continued to spend money as he did when he

was working by borrowing on credit cards, creating over $80,000.00 in credit card debt which they still have. He was able, through the help of a church member, to obtain a job in state government which does not pay nearly as well as the previous job.

The financial debt is a major stressor for Alice. John began working a second job, selling mortgages by phone, in order to help pay the bills. He works daily from eight am until eight pm. He has a one hour commute so he is away from home fourteen hours daily.

John wanted very much for Mary to be able to go to the state university which would add to their financial burden. Mary was able to obtain a small athletic scholarship and some academic scholarship money, but the amount was not enough to pay for all her expenses. She loves her father and wanted to please him by winning a full scholarship. She was very sad when she discovered the scholarships would not be enough. She believed she had deeply disappointed her father. John insisted that she go to the university anyway, have a car, and join a sorority. This would add significantly to the financial stress, but he wanted her out of their home town.

During the summer before she was to leave for college, John came home unexpectedly early and discovered Mary having sex with her boyfriend in their house. He was furious and became physically assaultive to the boy who later reported him to the local police. John was angry with Mary. He threatened to take everything away from her at one time. Alice, while not approving of the behavior of Mary and her boyfriend, felt John overreacted severely. She was caught in the role of peacemaker again. John kept drinking more alcohol.

John, at Alice's insistence, asked our pastor for counseling. He denied he was still angry. He denied any marital problems. The pastor referred him to me for assessment and counseling. John came by himself for the first appointment. He stated he was not angry and did not see what the big deal was with Alice and Mary. He believed he was being punished for being "a bad boy."

I asked him to invite Alice to come in with him after the second session. She stated that he seemed much angrier than before the incident. She thought he was trying to control every move Mary made. He said he was just trying to help her.

Mary told him that she is 18-years-old, and that he cannot control her. He says he does not want to control her; he just does not want her to mess up her life. Alice says she is at her "wits' end." She loves them both and believes John is wrong in the way he is dealing with the situation. She has lost one daughter and one husband to death. She doesn't want to lose anyone else.

Alice stated that she is reluctant to do couple counseling because they are very much in debt and because it is so emotionally draining. I believe she may be fearful that dealing with the truth will cause them to divorce. She also mentioned in passing, at the end of the session, that she had some concerns about John's alcohol consumption. She said she did not mind if he drank one or two drinks at a time, but that he was drinking more than that and embarrassing her in front of family and friends. John denied he has a problem with alcohol. Alice said she felt very guilty about saying anything about it, but it is really bothering her. They agree that they do love each other and are committed to the marriage.

Assessment

I reviewed John's history of addiction to drugs with both of them present. He began using marijuana, cocaine,

nicotine, stolen prescription medications, and alcohol when he was thirteen years old. He says he has not used marijuana or cocaine since 1980, but his alcohol consumption is high. He drinks "several stiff drinks" every night after he returns home from work. He drinks to the point of blacking out on occasions. He has also continued to smoke cigarettes after being diagnosed with emphysema.

I reviewed the *DSM-IV* criteria for Alcohol Dependence with John and Alice. He agreed that he, in fact, meets the criteria for that diagnosis, and it was a bigger problem than he realized. I informed them that there was nothing we could do to help heal other areas in the marriage until John was willing to quit drinking and work toward sobriety. He must turn from the false god of alcohol and turn to God for help. We identified strengths of the marriage as their strong spiritual beliefs and agreement on those. They both stated that they are committed to making the marriage work. John was angry about having to give up the alcohol but said he was willing to do it.

I administered two marital inventories, The Locke-Wallace Marital Adjustment Test and the ENRICH Marital Inventory. The Locke-Wallace indicated that they were both happy with their marriage. The significant areas of

disagreement were noted as their sexual relationship, how they settle disagreements, and how they spend their leisure time. Alice states that she always gives in during arguments, but John says they settle them mutually. Alice says that she has completely given up on their sexual relationship and believed that his lack of sex drive was her fault. She had even gone to the extreme of having weight loss surgery to make herself more attractive. John says he is just not aggressive enough. They have not had sexual intercourse for over three years.

The Enrich Inventory basically confirmed what they had self reported and agreed with the Locke-Wallace. I was concerned as to which of the Prepare-Enrich Inventories to administer because their children are technically out of the house. I chose the Enrich version as opposed to the MATE version because the presenting problem involved conflict about their daughter Mary. They were in the very center on the Couple and Family Map, indicating that they are connected and flexible. Their agreement on the Content Area of Spiritual Beliefs was 90%. Their agreement on Financial Management was 10%, Sexual Relationship 20%, Personality Issues 20%, Conflict Resolution 20%, Leisure Activities 40%, Communication 20%, Children and Parenting

70%, Family and Friends 40%, and Equalitarian Roles 80%. The "Type of Marital Couple" indicates that this is a conflicted couple which has few internal strengths in key areas. The suggested treatment plan is to build communication and conflict resolution skills.

I found the ENRICH Inventory to be somewhat confusing because it identified them as well balanced on the Couple and Family Map. They were both located right in the center of the grid. After some thought, I decided that that was a positive because they do want to heal the relationship, and they are willing to make the changes required. They want to get well, and they are both committed to God.

Individual Assessments

John appears to be depressed and obviously is alcohol dependent. His childhood was difficult, and his adolescence was total chaos. He may never have truly bonded in a healthy way with another human being. He lived for many years as a polysubstance dependent homosexual. He has indicated that he had compulsive sexual behaviors, picking up men on the streets at times. He became a bi-sexual polysubstance abuser. It was at that stage of his life that he had his conversion experience while high on cocaine and soon decided he would be celibate and not use cocaine. He

continued to smoke marijuana for a while. He has continued to drink alcohol and smoke cigarettes.

John states that he has been in a lot of previous psychotherapy and that he is an “open book.” He appeared to be playing mind games with me the first two counseling sessions, and I asked him if he was. Mary stated that he had a long history of lying to counselors before. John affirmed that he had. She stated that I was the first to ever bring up the alcohol abuse as an issue and hindrance to healing. I do not believe he has ever dealt with his past sexual abuse issues and his homosexual and bisexual life styles. His lack of sexual desire which has adversely affected their marriage for many years is possible evidence that he is controlling his sexual desires or that he is still confused about his own sexuality. I do believe he has been sexually faithful to Alice for the 21 years of their marriage. He has been in many ways obsessive or controlling in every thing he commits to do. He has controlled his use of cocaine and other drugs for years, but has not surrendered to alcohol. He worked full time in a factory after he and Alice were married and finished his college degree at night while helping to raise their children. He rose to a high level management position with a big company

before being laid off. He continued to spend money excessively, believing he could overcome the problem he was creating. He says he and Alice were making the decisions together; she says he was not listening to her so she quit talking about it. John lives in denial about many issues. He has worked very hard to serve the Lord. He has been involved for a long time in a prison ministry which requires a lot of time. He has had serious conflict with all three of their daughters because he wants them to have a better life than he has had. He has also caused difficulties with friends by telling them how they should fix their own lives. He believes he is trying to help. They interpret it as controlling and interfering in areas where he has no business. He stated that he believes he has wasted most of his life and wants to prevent them from doing the same.

Alice has Major Depressive Disorder and was taking Prozac when they first came to therapy. I believe it is complicated by the unresolved grief of the loss of her daughter and second husband. She overeats and states she turns to food for comfort. She probably would also be classified as having a Dependent Personality Disorder based on her extreme need to be in (or control) relationships and

willingness to tolerate a lot of difficulties to keep them together. Alice is willing to allow her mother to move into their home if her health deteriorates any further even though Alice's marriage is highly stressed. John says it is alright with him if his mother-in-law moves in. Alice is afraid their daughter Kim will not have a place to go if she and her husband separate. She would welcome Kim and her two children as well as her mother into their house at the same time. Alice is afraid of saying things in therapy sessions that might cause John to get angry. She has "given up" on having a healthy sexual relationship with him and does not discuss the financial problems because she believes it would be useless to do so. She has suffered from the death of her daughter, her father, and witnessed her second husband killed in a car wreck.

She states that she occasionally drinks alcohol, but never to excess. She does not use any illegal drugs or smoke cigarettes. Having grown up in an alcoholic home, she thought that John's drinking was normal for men. She does not mind him having "a drink," but his getting drunk and using offensive language to friends and relatives really bothers her. When she has mentioned his drinking too much before, he would not listen, so she has stopped telling

him. Once he was so drunk he urinated on the TV in a fit of anger. He was in a blackout and does not remember doing it.

Alice believes strongly that God will help her through these difficult times. She wants the marriage to be healthy and to set a good example for her daughters Kim and Mary.

Couple Assessment and Treatment Plan

The first step in the treatment plan has been to require that John stop drinking and attend weekly Alcoholics Anonymous Meetings. He has relapsed on at least two occasions over the past few months. He says he has attended weekly AA meetings, but I have some doubts. Alice will be attending Al-Anon on a weekly basis.

The Enrich Inventory, the Locke-Wallace Marital Adjustment Test, and my own evaluation with this couple suggest that the focus of marriage counseling should be on developing good communication skills and conflict resolution skills. We will focus on these goals using the Christian Prep Model or the Couples Communication and conflict management skills training programs. We will use cognitive behavioral therapy to help Alice and John both alleviate their depression. A psychiatric evaluation for antidepressant medication for John will be suggested. We will also use cognitive behavioral therapy for helping John

to obtain sobriety and deal with his unresolved issues of sexual abuse, his own sexuality, anger, and any guilt or shame he feels. We will hopefully help him to see the truth regarding his core belief of a wasted life. A Bible study of the books of Romans and Isaiah and other appropriate scripture will be incorporated.

Because both of them come from such dysfunctional families of origin, we will educate them on how a healthy family system works and help them to understand the biblical principles of complementarity and dependence on God's word for guidance. We will work on healthy stress management skills. We will locate a financial advisor who can help them to deal realistically with the heavy debt burden they carry. Making mutual, well informed decisions, about the stress of Alice's mother living with them and the issue of how to best help Kim will also be important. John is extremely idealistic in many of his ways of dealing with life especially in regard to financial issues. Alice is afraid to confront him about it. They both have a very low sense of self worth which I consider both a spiritual and therapeutic issue. They have gotten themselves into a genuine crisis.

They have both been involved in various prayer ministries at our church. Based on the work of S.Y. Tan, using cognitive behavioral therapy and inner healing prayer, I have suggested we ask the intercessory prayer team to pray for them and for a member of the inner healing prayer team to work with us. They have agreed.

A brief synopsis of the therapy process will be presented as an addendum to this thesis. The daughter, Mary, will be included in the therapy as we can. As stated earlier, I feel blessed to be able to work with this couple. They do care about each other and the Lord. They want to be healed. They are fearful of doing the work. So far they have stayed with the therapy and taken the risks necessary for growth. I am gaining a greater understanding of what a full time pastor might be going through at times because I see them at church on Sundays and occasionally serve on a ministry team with John. Maintaining boundaries is important and difficult at times. I believe with God's help we will be able to do this work he has set before us.

Diagnostic and Statistical Manual Diagnosis

John

Axis I: Alcohol Dependence 303.90
Nicotine Dependence 305.1
Marital Disorder V61.10
Dysthymic Disorder 300.4

Axis II: Dependent Personality Disorder 301.6

Axis III: Emphysema
Allergies

Axis IV: Economic Problems-severe

Axis V: 55

Alice

Axis I: Major Depressive Disorder 296.3
Marital Disorder V61.10

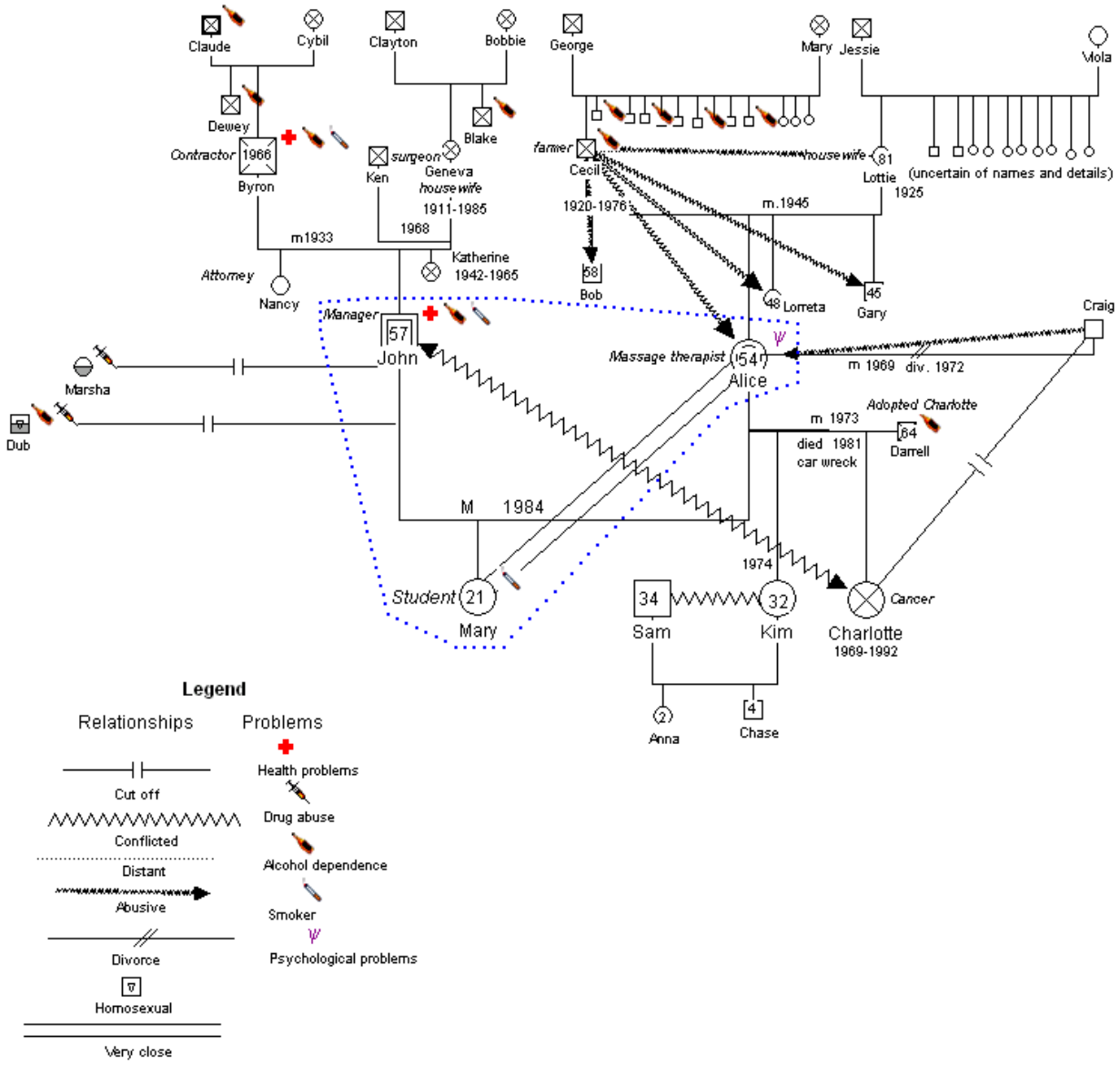
Axis II: Dependent Personality Disorder 301.6

Axis III: Back pain

Axis IV: Marital Problems-severe
Economic Problems- severe

Axis V: 60

John and Alice Family Genogram



Chapter Five

Lessons Learned:

Important Points for Counselors who Work with Addictions

This writer stated in the first chapter that addictions of all types are a major problem in this country today and that it is time for the Christian church to wake up and fulfill its role in healing. During the first six months of 2006 there were 38 homicides in this writer's medium size city. That is double the number during the same period last year. The police chief attributes the increase to drug related activities. If we are to fulfill the great commission given us by Jesus Christ, "...go and make disciples of all the nations..." (Mt.28), then we must step out from our own comfort zones and address this problem. All Christians must become more aware of the problems being caused by addictions. Church leaders must take responsibility to obtain education and to educate their members. Those who counsel others in any capacity must develop a basic knowledge about addictions and how to treat them. The church must take a much bigger role in prevention and healing.

The family that has been the subject of this dissertation has been a difficult one with which to work. All families affected by addictions are. There are several important principles which this writer believes any one who counsels others should be aware of and apply if he or she is going to be of help.

First, we are not God. Earlier, in describing some characteristics of addictive thinking, the writer stated that people who become addicted struggle with the distorted belief that they are God and can control their use of the drug alone.

Dallas Willard (2002) suggests that all humans find it offensive to be confronted with the fact that they are not God. Those of us in the helping professions also seem to struggle with the fact that we are not God in at least two ways. One is that we, especially Christians, tend to be judgmental of people who are addicted to drugs and behaviors, especially sex and gambling. This writer was once told that shame and guilt are the pillars on which addictions are built. When a person who has an addiction tries alone to stop and fails, he or she feels shame and guilt. The more the person feels the pain of shame and guilt the more he or she will likely turn back to the drug

to numb the pain. While never approving sin, counselors should represent Christ by reflecting his love and grace for all humanity.

> Why does your teacher eat with such scum?' they asked his disciples.
> When he heard this, Jesus replied, 'Healthy people don't need a doctor sick people do.' Then he added, 'Now go and learn the meaning of this Scripture: I want you to be merciful; I don't want your sacrifices. For I have come to call sinners, not those who think they are already good enough (Mt.9:10-13).

A second way is that counseling professionals have too often tried to "do it all" with out seeking help from others. James Emery White, in his book *Serious Times* quotes the existentialist philosopher Jean Paul Sartre as saying "Man is the being whose project is to be God (White, 2004, p.42)." As counselors in any setting, knowing our own limitations and the resources available to help us to help others is critical. Jesus sent his disciples out in pairs, not alone. Counselors should seek guidance from God and from those whose training and experience in areas of addictions are greater than their own. Appropriate referrals to specialists, treatment centers, and support groups such as Alcoholics Anonymous and Celebrate Recovery are very important for long term healing.

The case presented in this study clearly pointed out that the "presenting problem" is not always "the" problem.

John's anger and controlling behavior were symptoms of much deeper problems. No one in this family intended to become an addict or to reinforce the addictive thinking and behaviors. Assigning blame would have been counter-productive. John and Alice are products of their dysfunctional families of origin. Mary is a product of hers. If they are to heal, they must accept the responsibility for doing the work.

As counselors we must be aware that there are often deeper issues than first identified by our clients. A wise therapist will continue to probe. For the good of the client, we must be caringly skeptical of their initial answers regarding substance abuse or addictive behavioral problems on intake forms and personal interviews. If a substance or behavioral addiction exists, it is a family problem and all members of the family should participate in the healing. As previously stated, the sooner the treatment begins, the higher the probability of success.

It is also important that the counselor be fearlessly honest with clients. Fear of confronting a person or family about addiction hinders treatment of any other problem. An experienced counselor will expect denial and minimization. Understanding the basic dynamics of an addictive family

system is important. A complete assessment, including a genogram which reflects the family history of substance abuse and addictions, will aid the counselor and the family to understand the impact of the client's family of origin. In cognitive behavioral therapy terms, a family developmental perspective may reveal how they developed their core beliefs.

Roberts and McCrady (2003), emphasize the importance of screening every family member over 18 years-of-age for alcohol abuse or dependency. This writer believes it would be wise to include children as young as thirteen. The writer recently counseled with a family whose 14-year-old son had stolen credit card numbers from his mother and had accumulated over $15,000.00 in debt due to internet gambling. The father, a gambling addict himself, had taught him how to "handicap" horse races. Many early teenagers today are smoking marijuana, drinking alcohol, using methamphetamine, gambling, and watching pornography on the internet.

Counselors cannot be experts in every area of mental health care. This writer believes that it is imperative that all counselors, pastors, and other health care professionals obtain some training about addictions. It is

important to know the signs and symptoms to look for as well as the different treatment strategies and goals. The alcohol dependent person must learn to lead a healthy life while totally abstaining from alcohol and other mood altering drugs for life. The sexually addicted person must learn how to have a genuine loving relationship with another person which includes a healthy sexual relationship within marriage.

John and Alice have just begun the healing process. We will continue the counseling for as long as it is needed. The counselor must be careful to encourage dependency on God and others, not the counselor. John's addiction to alcohol and Alice's dependency issues significantly hampered progress in implementing the total treatment plan we developed. We started in December of 2004, John continued to drink and deny it until one week before Christmas of 2005. He has not had alcohol for six months. The difficulties and the slow progress demonstrate how deep the problems of substance and behavioral addictions really are. The attachment John has to alcohol is very strong and Alice's attachment to her children, her mother, and her husband are equally powerful. As a counselor for many years, this writer has not been surprised or particularly

discouraged about the lies, the lapses, and the other problems which have hampered the progress.

As a Christian counselor, the writer was somewhat naïve. The writer had unrealistic expectations that because both John and Alice were very active members of his own church; they would somehow be more motivated to heal than other clients. This experience has been a real growth process for the writer as a Christian marriage and family therapist. It is important for all who counsel with people who have addictions to recognize our own powerlessness, as well as our client's. We must have faith and patience.

Initially the author was excited about the using inner healing prayer as an addition to the counseling. We were able to work in only one inner healing prayer session. John's time is extremely limited due to his two jobs. The inner healing prayer session we held was very powerful for John's healing of a deep rooted core belief that he was a "child whore." He spent his life acting on that belief as a promiscuous homosexual and then bisexual man. He tried to numb the pain of it by turning to drugs and alcohol.

Alice has lived in fear most of her life. She tried to be a peacemaker in her chaotic abusive family of origin. She felt like a failure there. She got pregnant and then

married in order to escape. She first married a physical abuser. Then an alcoholic who died in a car wreck which she witnessed. Her third husband, John, is another alcoholic. She keeps trying to be "good enough" and failing every time in her own eyes.

The writer thought it would be easier to help both of them to see the truth about themselves and to get well faster because they seemed like such good Christians. What this writer learned is that good Christians can be deeply hurting human beings.

The author stated earlier that his counseling methods are based on Scripture and the cognitive behavioral theory and therapy developed primarily by Aaron Beck and his associates. One of the key elements that Beck describes for a positive therapeutic outcome is that the therapist must develop a warm, caring relationship with the clients. The clients must perceive that the therapist is competent and committed to helping them. Given the history of both John and Alice, this writer feels honored that either of them would trust him as far as they have. It is only with the help of God that the writer has been able to have any impact on their lives. They still have a long way to go before their goals will be met. There will be difficulties.

There were times when the author wanted to terminate the therapy because either John or Alice did not seem committed. There were many prayers for guidance and patience.

This writer chose cognitive behavioral therapy as a model for counseling because it has been well researched and found to be effective. It is not the only effective tool. It does not pretend to be. The developers were well grounded in all theories of psychology. Cognitive behavioral therapy has been adapted into family therapy with promising results. A well trained cognitive therapist must think systemically. Its theory and therapy techniques for substance and behavioral addictions are effective. The cognitive behavioral model for treating substance and behavioral addictions is consistent with Scripture. Jesus taught us that we should build on a firm foundation, not sand. Christian cognitive behavioral therapy helps the clients to recognize the distorted core beliefs on which they have built their lives and to replace them with truth.

The success rate in treating addictions, no matter the psychological orientation of the therapist or treatment center, is not very high. The key element for success is not the theory or techniques or the therapist. The key

element is dependence on God. It is the belief of this writer that we have many well trained people in the fields of medicine, religion, and mental health that see substance and behavioral abuse and addictions from a single point of view. They try to treat the problem from one perspective. The Apostle Paul teaches us that we are all members of the Body of Christ and that we all have different functions. If the Body of Christ is to function well, we must acknowledge each other and work together (1 Cor.12). No one person or professional discipline has the answer to the healing of addictions. Substance and behavioral addictions would no longer be a growing problem if one did. From this counselor's perspective, we in the helping professions must see the healing power of God as the force that empowers our work. We must see our selves as members of the Body of Christ; each member working together using the gifts, talents, and skills he has provided to achieve the plans he has for us and to help those he has blessed us to work with.

Eight years ago, the writer's younger brother lay dying from lung cancer which was a result of his addiction to nicotine. We were told he would not live through the day. The writer's wife called our new church to request

someone from the prayer ministry to come and pray with us. John was the one who took time off from his work to come to the hospital and lead our family in prayer.

As a part of the writer's ministry to help others over the past few years, he worked with a recovery program at his church. We meet each Wednesday night for a meal, Bible study, worship, and group therapy. People from all walks of life attend. Some are still addicted and some are sober. We are financially and racially diverse. We have become a family.

One night a few months ago, the writer shared the story of having been called to the Christian high school his stepson attended. The principal told us he was confused and disoriented. The writer and his wife, a psychiatrist, rushed to the school and then took our son to the emergency room at a hospital. There we learned that he had accidentally overdosed on a tranquilizer. He had purchased the two milligram Xanax pills from another student. Our son had not been doing well in school for several years. He had failed to pass ninth grade the first time and was not doing well in the tenth grade. He had learned on that day that he would not be academically eligible for sports. He felt stressed. He bought some "chill pills" from another high

school student who was known to sell drugs. Our son was expelled from the school for buying the drugs. He knew better. He had seen other mental health professionals for evaluations and counseling.

The writer told the group of our family pain as we were about to send our son to a nearby Christian youth ranch. We were going to have to truly turn him over to God and other people because all we had been doing to help him was not working. We were going to have to change. He was going to have to be willing to accept help.

One man of a different race, Jimmy, who has some brain damage from drug abuse and lives in an assisted living center, told the writer afterward that he would pray for us. For the past four months at each meeting when the writer sees Jimmy he says “How’s that boy of yours? I’m praying for him.” That boy is healing. He is turning to God.

Addendum

Summary of Progress Notes

December 30, 2004:

John came to me for counseling after referral from the senior pastor at our church. He stated his wife, Alice, and daughter, Mary, were accusing him of still being angry six months after an altercation described previously in chapter four. He denied that he was. John stated he had seen numerous counselors in the past and that he had all of his "stuff" worked out. He said he was a little "pissed off" about having to see another counselor, but would do whatever he had to in order to "get them off his back."

I did an extensive initial assessment and suggested John come back for a second time alone, and then with Alice. He agreed.

January 2005:

We continued the assessment process. The complete diagnosis is related in chapter four of this dissertation.

John stated that Alice was reluctant to come in for counseling because she is very busy. She believes it is his problem and they are in a financial bind.

I briefly explained how cognitive behavioral family counseling works and asked him to encourage her to come for the next counseling session.

Alice came with John for the third session. She gave details of her concerns about his behaviors and expressed fear that he would be angry with her if she were honest in the counseling sessions.

I emphasized the importance of her participation and she agreed to participate. As we were completing the session, Alice mentioned that she had some concerns about John drinking too much on some occasions. She stated she was afraid he would get angry and quit counseling if she brought it up. John said he didn't think it was a problem, but he would talk about anything.

February 2005:

We held our first family session with Mary.

I met with Mary privately first. She stated she loved her father. She believed she had never been able to please him. She had disappointed him by not winning a full scholarship to the university. She believed he was still angry with her and he was trying to control her life.

In a full family session, Mary expressed her feelings to her father. He was surprised at how deeply she was hurt

by his statements about her partial scholarship and that she never felt like she pleased him.

This session helped to make some of the issues clearer for me and for John and Alice. John was able to assure Mary that he had miscommunicated his feelings to her and that he was proud of her.

As therapy progressed during the month, Alice confronted John about his continuing to smoke cigarettes and drink alcohol. John denied he was smoking. Alice stated she had seen him and found two packs of cigarettes. He said he would stop.

I affirmed my diagnosis that John has Alcohol Dependence and that he must stop drinking and attend Alcoholics Anonymous if he is going to make progress. He stated he did not think it was as big of a problem as I did. Alice described situation a few months previously in which John had gotten drunk and angry at something someone said on a television show. He had urinated on the television. John did not remember it.

I reviewed the description of blackouts from the DSM-IV for them.

April 2005:

John came alone. He stated he had gotten drunk again at a family gathering over the Easter holiday. He felt ashamed. I reviewed again the need for him to surrender to his addiction to alcohol.

The next session I used guided discovery to help Alice understand that John's having to stop drinking was not her fault. She felt guilty about it.

John agreed to attend one Alcoholics Anonymous meeting a week. He had been lying about previous attendance.

We started a Genogram which helped them to see the history of addiction to alcohol on both sides of their families.

May 2005:

John came for an individual session. He had not had a drink for two weeks. John stated that it made him angry to think he could not drink alcohol again for the rest of his life. We discussed the meaning of the AA motto "one day at a time."

I also asked him to think about which he valued more; his family or alcohol.

June 2005:

I was away for two weeks attending a D.Min. residency. John and Alice were away on vacation.

July 2005:

John and Alice returned for first counseling session in six weeks. Alice was very angry and discouraged. She mentioned divorce for the first time.

John had arrived at their vacation condominium drunk. He drank during the entire two weeks he was there. He also smoked cigarettes. John stated he had thought he was entitled to have a few drinks because he had been a "good boy" for the previous month.

I again reviewed the symptoms of Alcohol Dependence Disorder with John and Alice. John's lapse was a predictable symptom of the disorder. Both of them seemed to accept more deeply how serious John's alcohol addiction really is.

We decided to increase the frequency of the therapy sessions and to include inner healing prayer and to ask the intercessory prayer ministry at our church to pray for them.

August 2005:

John and Alice completed the Enrich Marital Inventory and the Locke-Wallace Marital Adjustment Test. Both instruments indicated that they were significantly satisfied with their marriage. Their strong spiritual values were a significant area of strength. Conflict management and communication skills were indicated as areas that should be improved.

During the review process, Alice stated she had not been completely honest about the sexual and financial questions. She believed that John would not listen to her feelings about these two subjects and that she was very discouraged about ever resolving them.

John stated she was unrealistic in her fears about debt and that the sexual problems were his responsibility. He stated he does not have a very high sex drive and has some health issues causing erectile dysfunction.

September 2005:

Hurricane Katrina destroyed the house and workplace of Alice's brother. She went to Mississippi to assist him. Her mother's health grew worse and Kim's marriage deteriorated. It was a stressful month for both Alice and John.

John did not drink. Alice was encouraged by that.

October 2005:

We held one session of inner healing prayer with John.

John was asked to be aware of his anger and of the sexual abuse he had experienced as a child. He was encouraged to allow the Holy Spirit to speak to him in some way about it. John was able to recall some memories of the abuse by the older neighbor boy. John had always thought of himself as a willing participant. He was able to remember during this time that the older boy had been blackmailing him. John stated "I was a child whore." He was asked to allow the Holy Spirit to help him see the truth. He was six years old and his father was very sick. They had little money. The boy's family was giving him clothes to wear. John was afraid that if he told, or didn't do what the boy wanted, he wouldn't have clothes to wear. He was not a "child whore" or willing participant.

John was able to begin the process of forgiving the perpetrator and himself.

John planned a surprise picnic for Alice which meant a lot to her. The hoped for sexual encounter was ruined by a phone call from Alice's mother who needed some immediate assistance.

Alice was encouraged that he at least made an effort.

November 2005:

John has continued to attend AA and not drink for more than 30 days.

The Monday after Thanksgiving John came in alone. He had relapsed over the holidays while visiting at his sister's. There had been a fight with Alice and with Mary. He was ashamed. He stated he did not realize how fast the addiction could take over again. He said he really wanted to get sober.

December 2005:

Alice expressed her anger about the incident during Thanksgiving. She was also angry because she did not believe John was trying to help their daughter Kim. John apologized again for getting drunk. He stated he loved Kim and would do all he could to help her.

The next week John came alone. He had relapsed once again. He started drinking with a friend and continued to drink all day while doing repair work on their rental house. John had passed out, fallen down and scraped his face badly. Alice was called to come 50 miles to pick him up and drive him home.

Alice was furious.

Our clinic would be closed for the next two weeks for the Christmas holidays. I assured them I would be available for emergencies.

January 2006:

John stated he did not realize how sick he really is. He admitted again that he had continued to lie to Alice and me. He thought he could "just get them off his back and start drinking again." He had attended AA meetings daily since before Christmas.

We reviewed again how addictive thinking works and the need for complete surrender.

February 2006:

John continued to attend AA on a daily basis and obtained a sponsor. He did not see himself as having all the kinds of problems "those people" at the meetings had, but he was attending. He seemed to be making some progress.

March 2006:

John began to show evidence that he understands how significant his addiction to alcohol is. He stopped referring to other AA members as "those people." He was accepting his problem and no longer comparing himself to others.

April 2006:

John continued to abstain from drinking and to attend AA meetings daily. He received his pin for 90 days of abstinence.

He was able to discuss in depth how much his problem has affected everyone in his family. He was able to stop blaming himself for all the family problems. He began to take responsibility to heal them with Alice's help.

Alice was able to detach more from the problems of her mother and daughters. She began to focus on the marriage and solving the significant financial problems.

We began work on the communication and conflict resolution skills which were originally part of the treatment plan.

Counselor's Summary

Counseling with all families is difficult. Counseling with families affected by addiction requires both patience and a deep understanding of addictions. John continued to drink for one year after he began therapy. That is fairly common in this writer's experience. The key element for success so far has been to earn his trust while staying firm in the belief that healing of other issues in the

marriage could not happen until he started on the road to sobriety.

This couple has just started to deal with their other issues after eighteen months of counseling. They could not work on them effectively as long as John continued to drink. They have a lot of problems to work on and we will continue to do that with God’s help. This writer felt discouraged at times. Prayer and asking for guidance from my supervisor and others helped.

Bibliography

Alcoholics Anonymous (2001). *Alcoholics anonymous* (4th ed., Rev.). New York: Alcoholics Anonymous World Services, Inc.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Rev.). Washington, D.C.: American Psychiatric Association.

Beck, A. T., Rush, A. J., & Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford Press.

Beck, A. T., Wright, F. D., Newman, C. F., & Liese, B. F. (1993). *Cognitive therapy of substance abuse.* New York: The Guilford Press.

Beck, J. S. (1995). *Cognitive therapy: basics and beyond.* New York: The Guilford Press.

Breaking the cycle of addiction. (n.d.). Retrieved February 24, 2006, from http://ncadi.samsha.gov

Carnes, P. (2005). *Facing the shadow: starting sexual addiction and relationship recovery* (2nd ed.). Carefree, AZ: Gentle Path Press.

Carnes, P. J., & Adams, K. M. (Eds.) (2002). *Clinical management of sexual addiction.* New York: Brunner-Routledge.

Carnes, P. J., & Wilson, M. (2002). The sexual addiction assessment process. In P. Carnes & K. Adams (Eds.), *Clinical management of sexual addiction* (pp. 3-19). New York: Brunner-Routledge.

Center For Substance Abuse Treatment (2004). *Core competencies for clergy and other pastoral ministers in addressing alcohol and drug dependence and the impact on family members.* Washington, D.C.: Substance Abuse and Mental Health Services Administration.

Comings, D. E. (1998). The molecular genetics of pathological gambling. *CNS Spectrums the Journal of Neuropsychiatric Medicine, 3*(6), 20-35.

Cox, S., Lesieur, H. R., Rosenthal, R. J., & Volberg, R. A. (1997). *Problem and pathological gambling in America: the national picture.* Columbia, MD: The National Council on Problem Gambling.

Dattilio, F. M. (1998). Cognitive behavioral family therapy. In F. Dattilio (Ed.), *Case studies in couple and family therapy: systemic and cognitive perspectives* (pp. 62-84). New York: Guilford Press.

Dattilio, F. M., & Padesky, C. A. (1990). *Cognitive therapy with couples.* Sarasota: Professional Resource Exchange, Inc.

Dattilio, F. M., Epstein, N. B., & Baucom, D. H. (1998). An introduction to cognitive behavioral therapy with couples and families. In F. Dattilio (Ed.), *Case studies in couple and family therapy: systemic and cognitive perspectives* (pp. 1-35). New York: Guilford Press.

Epstein, N. B., & Baucom, D. H. (1998). Cognitive behavioral couple therapy. In F. Dattilio (Ed.), *Case studies in couple and family therapy: systemic and cognitive perspectives* (pp. 37-61). New York: Guilford Press.

Epstein, N. B., & Baucom, D. H. (2002). *Enhanced cognitive-behavioral therapy for couples: a contextual approach.* Washington: American Psychological Association.

Forgatch, M. S., & Patterson, G. R. (1998). Behavioral family therapy. In F. Dattilio (Ed.), *Case studies in couple and family therapy: systemic and cognitive perspectives* (pp. 85-107). New York: Guilford Press.

Friedman, E. H. (1985). *Generation to generation: family process in church and synagogue.* New York: The Guilford Press.

Greenberger, D., & Padesky, C. (1995). *Mind over mood: change how you feel by changing the way you think.* New York: The Guilford Press.

Hawkins, R. S., Tan, S. Y., & Turk, A. A. (1999). Secular versus Christian inpatient cognitive-behavioral therapy programs: impact on depression and spiritual well being. *Journal of Psychology and Theology, 27,* 309-318.

Kaslow, F. W. (Ed., 1996). *Handbook of relational diagnosis and dysfunctional family patterns.* New York: John Wiley & Sons, Inc.

Laaser, M. (2004). *Healing the wounds of sexual addiction* (3rd ed., Rev.). Grand Rapids, MI: Zondervan.

Lesieur, H. R. (1984). *The chase, career of the compulsive gambler.* Rochester, VT: Schenkman Books, Inc.

Lesieur, H. R. (Ed.). (n.d.). *Identification & treatment of pathological gambling*. Peoria, IL: Proctor Hospital.

Manning, B. (2002). *Abba's child: the cry of the heart for intimate belonging* (2nd ed.). Colorado Springs: NavPress.

May, G. G. (1988). *Addiction and grace.* New York: HarperCollins.

McGoldrick, M., Gerson, R., & Shellenberger, S. (1999). *Genograms: assessment and intervention* (2nd ed.). New York: W.W. Norton & Company.

McNutt, F. (1999). *Healing* (Rev. ed.). Notre Dame, IN: Ave Maria Press.

National Council on Problem Gambling. (2005). *Questions and answers about the problem of compulsive gambling and the G.A. recovery program*. Retrieved from http://www.ncpgambling.org

Nichols, M. P., & Schwartz, R. C. (2001). *Family therapy concepts and methods* (5th ed.). Boston: Allyn and Bacon.

Padesky, C. A., & Greenberger, D. (1995). *Clinician's guide to mind over mood.* New York: The Guilford Press.

Roberts, L. J., & McCrady, B. S. (2003). *Alcohol problems in intimate relationships: a guide for marriage and family therapists.* Washington D.C.: National Institute on Alcohol Abuse and Alcoholism.

Scazzero, P. L., & Bird, W. (2003). *The emotionally healthy church: a strategy for discipleship that actually changes lives.* Grand Rapids, MI: Zondervan.

White, J. E. (2004). *Serious times: making your life matter in an urgent day.* Downer's Grove, IL: InterVarsity Press.

Willard, D. (2002). *Renovation of the heart: putting on the character of Christ.* Colorado Springs: NavPress.

Williams, T. G. (1996). Substance abuse and addictive personality disorders. In F. Kaslow (Ed.), *Handbook of relational diagnosis and dysfunctional family patterns* (pp. 448-462). New York: John Wiley & Sons, Inc.

Yarhouse, M. A., Butman, R. E., & McCray, B. W. (2005). *The modern psychopathologies: a comprehensive Christian appraisal.* Downer's Grove, IL: InterVarsity Press.

Vita

William Alexander Wilson

Business Address:
Lakewood Behavioral Health Associates, LLC
4020 Richards Road
Suite F
North Little Rock, AR 72117
Phone: 501-753-1616
E-mail: bwilson@lakewoodbehavioralhealth.com

Date and Place of Birth:
May 11, 1944
Little Rock, AR

Thesis Work:
2006

Education:

D. Min., 2007	Marriage & Family Therapy Gordon-Conwell Theological Seminary, Charlotte, NC
M.A., 1980	Marriage, Family & Child Counseling Chapman University, Orange, CA
B.A., 1966	Social Sciences, Hendrix College Conway, AR

Professional Position:
Clinic Director
Lakewood Behavioral Health Associates, LLC

Licenses and Certifications:
Licensed Marriage and Family Therapist
Licensed Professional Counselor
Master Addictions Counselor
Certified Employee Assistance Professional

Professional Memberships:
American Association for Marriage and Family Therapy
Association of Marriage and Family Ministries
American Counseling Association
American Association of Christian Counselors
Employee Assistance Professionals Association